

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016493

STATE FILE NUMBER

FILED APR 18 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3949

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 4052 Oleatha Ave</b>		Length of stay in lb <b>68 yrs 4-16</b>	d. STREET ADDRESS <b>4052 Oleatha Avenue</b>
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>ANTHONY</b> Last <b>STEINER</b>			4. DATE OF DEATH Month <b>April</b> Day <b>8,</b> Year <b>1958</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1889</b>
9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>drug store</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Phillip J. Steiner</b>		13b. MOTHER'S MAIDEN NAME <b>Barbara Weber</b>	14. NAME OF HUSBAND OR WIFE <b>Delores Washburn</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW I</b>	16. SOCIAL SECURITY NO. <b>490-32-2231</b>	17. INFORMANT Address <b>Mrs. Delores Steiner, 4052 Oleatha Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) <b>Arterio Sclerotic Heart Disease</b>			<b>years</b>
DUE TO (c) <b>Coronary Thrombosis</b>			<b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>1955</b> to <b>4-8-58</b> and last saw <sup>him</sup> alive on <b>4-7-58</b> Death occurred at <b>5:00 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Hugh Hayes MD</b> (Degree or title)		22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED <b>4-8-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Apr. 11, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) <b>Jefferson Barracks, Missouri</b> (State)
24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave</b>		25. DATE RECD. BY LOCAL REG. <b>APR 9 '58</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Pugh Haynes  
3720 Washington Ave.  
2-5:30 PM except Sat.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4520  
P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.