

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023786
STATE FILE NUMBER

FILED JUN 16 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

5699

5. 300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>University City</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hos'p</i>		Length of stay in 1b <i>a few hrs</i>	d. STREET ADDRESS (If outside, give location) <i>6665 Washington</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>CHARLES STEINER</i>			4. DATE OF DEATH Month <i>5</i> Day <i>30</i> Year <i>1958</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25, 1883</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>	9. AGE (In years of birthday) <i>75</i> 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) <i>Merchant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis Mo.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13a. FATHER'S NAME <i>Sigmund Steiner</i>	13b. MOTHER'S MAIDEN NAME <i>Charlotte Asher</i>
14. NAME OF HUSBAND OR WIFE <i>Sara Lorie Steiner (Deceased)</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>494-09-1593</i>
17. INFORMANT Address <i>Malcolm Steiner, 7435 Buckingham</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0</i>	
19. INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>		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.) <i>420.0</i>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <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 Death occurred at <i>8:00 P.M.</i> on <i>4/15/52</i> to <i>5/30/58</i> and last saw him alive on <i>5/30/58</i> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>Harry Segren M.D.</i>	
22b. ADDRESS <i>634 N. Grand, St. Louis Mo.</i>		22c. DATE SIGNED <i>5/31/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		23b. DATE <i>6/1/58</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Sinai</i>		23d. LOCATION (City, town, or county) (State) <i>8400 Gravois Ave</i>	
24. FUNERAL DIRECTOR <i>Mayer, 4356 Lindell Blvd</i>		25. DATE RECD. BY LOCAL REG. <i>JUN 2 '58</i>	
26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Elmer R. Sander

Licensed Embalmer No. 4077
P. O. Address St. Louis

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.