

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007668
STATE FILE NUMBER
2 1616

FILED MAR 2 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
1-57
6
91
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in 1b 60 yrs.	d. STREET ADDRESS (If outside, give location) 2632a Accomac Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last THEODORE STEDINGK			4. DATE OF DEATH Month Day Year February 13, 1959		
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5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 19, 1882	9. AGE (In years, months, days) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Red Bud, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Carl Stedingk	13b. MOTHER'S MAIDEN NAME Emelia Schrieber	14. NAME OF HUSBAND OR WIFE Mrs. Caroline Stedingk
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Caroline Stedingk Address 2632a Accomac
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18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Edema - Cerebral Stroke</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>Seven yrs</i> <i>Seven yrs</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) <i>Generalized Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Obesity Generalized Sinus Changes</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>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from <i>4/7/55</i> to <i>2/19/59</i> and last saw him alive on <i>2/12/59</i> Death occurred at <i>1:00 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Arthur H. Hefner</i> (Printer or title)	22b. ADDRESS <i>3108 S. Grand</i>	22c. DATE SIGNED <i>FEB 13 1959</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 16, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.
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24. FUNERAL DIRECTOR Beiderwieden F.H.Inc., 1936 St. Louis	25. DATE RECD. BY LOCAL REG. FEB 16 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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71.9.13

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

R. ...
2,330
5,331

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.