

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011416
STATE FILE NUMBER
2955

FILED APR 6 1958 Registration District No. Primary Registration District No. Registrar 2

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hosp.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>5424 Minnesota</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Matilda Stebe</u>			4. DATE OF DEATH Month Day Year <u>Mar. 22, 1959</u>		
--	--	--	--	--	--

5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1877</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-------------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	---	--

13a. FATHER'S NAME <u>Jacob Seib</u>	13b. MOTHER'S MAIDEN NAME <u>Barbara Boehm</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Stebe</u>
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT Address <u>Geo. Stebe 5424 Minnesota</u>
--	---------------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver, metastatic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of gall-bladder</u>	<u>6 mos?</u>
	DUE TO (c) <u>Cholelithiasis</u> <u>155.1</u>	<u>4 years?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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
---	---	--	--

21. I attended the deceased from <u>Dec. 3, 1958</u> to <u>March 22, '59</u> and last saw ^{her} him alive on <u>March 22, 1959</u> Death occurred at <u>420 a.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Iseo A. Seib</u>	22b. ADDRESS <u>2323 Lafayette Ave. St. Louis</u>	22c. DATE SIGNED <u>3/23/39</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>3-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Lemay 23, M.</u>
---	-----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 24 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
--	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57
96
0

All diseases in Part I must be causally related.

Mr Geo. Seb
2323 Lafayette
Pr 6-2323

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 *Louis Van Fossan*

Licensed Embalmer No. *4242*
P. O. Address *St Louis Mo.*

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.