

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023429
STATE FILE NUMBER
2-5955

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</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>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN Hosp.</u>		Length of stay in 1b		d. STREET ADDRESS <u>5931 CORONADO</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE F. STEITZ</u>			4. DATE OF DEATH <u>JUNE 21 1959</u> Month Day Year		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 22 1877</u>	9. AGE (In years) <u>82</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Month(s) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TRUCK DRIVER CHAMBERS Motor.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>	
13a. FATHER'S NAME <u>REINHARD F. STEITZ</u>		13b. MOTHER'S MAIDEN NAME <u>JEANETTE KERN</u>		14. NAME OF HUSBAND OR WIFE <u>OLIVIA STEITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>492-05-1932</u>		17. INFORMANT Address <u>OLIVIA STEITZ 5931 CORONADO</u>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Certain degree Myocarditis.</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old cerebro vascular accident - Pt.</u>					INTERVAL BETWEEN ONSET OF DEATH <u>10 min</u> <u>Year</u>
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.) <u>—————</u>			
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.) <u>—————</u>		20f. CITY, TOWN, OR LOCATION <u>—————</u>		COUNTY <u>—————</u>	STATE <u>—————</u>
21. I attended the deceased from <u>1940</u> to <u>6/21/59</u> and last saw ^{her} him alive on <u>6/20/59</u> . Death occurred at <u>12:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name and title) <u>G. N. [Signature]</u>			22b. ADDRESS <u>5203 Cheppern.</u>		22c. DATE SIGNED <u>6/23/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>JUNE 24 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
24. GENERAL DIRECTOR <u>Thomas Kates 2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 23 '59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2-5 Presiding

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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 7906 Lewis

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.