

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034362**

**FILED VS OCT 5 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8712** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission)			
a. COUNTY				a. STATE <b>MO.</b>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>40 Yrs.</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePAUL Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4255 Farlin</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>AMANDA J. STEUTERMAN</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>9-20-1959</b>				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3/23/96</b>	<b>9. AGE</b> (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Columbia, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>Unknown</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Fred</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <b>Jesse Steuterman- 4244 Farlin</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural abscess, dorsal spine</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)	
						DUE TO (c) <b>342 x</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>hypertension &amp; cardio-vascular disease</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>	
<b>21. I attended the deceased from</b> <b>Aug 24 - 1959</b> to <b>Sept 20 - 1959</b> and last saw her alive on <b>Sept 19 - 1959</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Deed or title) <b>John G. M. Turner M.D.</b>				<b>22b. ADDRESS</b> <b>5014 Thekla Av</b>			<b>22c. DATE SIGNED</b> <b>9/22/59</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE</b> <b>9-23-1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>St. Trinity Lutheran</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Mo.</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>McLAUGHLIN'S, 2301 Lafayette Ave.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 2 259</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Leon Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 R. Chapman

Licensed Embalmer No. 4550

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.