

**FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH**

**59-042556**

**FILED VS DEC 11 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **211061** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in Tb <b>18 days</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>367 N. Boyle</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>O.</b> Middle <b>George</b> Last <b>Steding</b>			4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>59</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-16-89</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Sales Tax Office</b>		11. BIRTHPLACE (City and state or country) <b>Bowling Green, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>George Steding</b>		13b. MOTHER'S MAIDEN NAME <b>Corar Mackey</b>	
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>487-28-1500</b>	
17. INFORMANT <b>Richard Steding</b>		Address <b>1001 Glenbrook Glendale, Mo</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Chronic Basilar Congestion of Heart</b>		<b>18 days.</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease</b>		<b>18 days.</b>
DUE TO (c) <b>Generalized Arteriosclerosis</b>		<b>18 days.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus - 18 days. 420.0</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	
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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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 <b>11-10-59</b> to <b>11-28-59</b> and last saw her/him alive on <b>11-28-59</b> Death occurred at <b>10:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>		22b. ADDRESS <b>5800 Arsenal</b>		22c. DATE SIGNED <b>11/30/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-5-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bowling Green, Mo.</b>		23d. LOCATION (City, town, or county) <b>Bowling Green, Mo.</b>
24. FUNERAL DIRECTOR <b>C.L. Lupton &amp; Sons 7233 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 30 1959</b>	26. REGISTRAR'S SIGNATURE <b>Lead 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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864

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.