

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021579

FILED VS MAY 23 1960

2 4521

STATE FILE NUMBER

INDEXED

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)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		c. CITY OR TOWN Webster Groves	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 213 Euclid	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Steinkamp			4. DATE OF DEATH Month 4 Day 26 Year 60		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/30/18	9. AGE (last birthday) 41	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asbestos Worker	10b. KIND OF BUSINESS OR INDUSTRY Contractor	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	---	--

13a. FATHER'S NAME Edna Harry Steinkamp	13b. MOTHER'S MAIDEN NAME Edna Randolph	14. NAME OF HUSBAND OR WIFE None
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 2	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT William Randolph, 4345 Conn., St. Louis, Mo.
---	---	--

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) ASHO c congestive		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ASHO + Fibro Plsostosis of Endocardium 10YR.	
	DUE TO (c) 420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 **1955** to **4/26/60** and last saw him alive on **4/26/60**
Death occurred at **11 P. m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dorwin E Lewis, M.D.	(Degree or title)	22b. ADDRESS 100 N. Euclid	22c. DATE SIGNED 4/27/60
---	-------------------	--------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/29/60	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) Jeff. Brk's., Mo.
---	-----------------------------	---	---

24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette, St. Louis	ADDRESS	25. DATE RECD. BY LOCAL REG. APR 28 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
--	---------	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 James R. Chapman
Licensed Embalmer No. 45
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.