

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036806

FILED VS SEP 21 1960

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2702

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS COUNTY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves,</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>395 days</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>Glenwood Home &amp; Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>468 Laurel</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Oskar</b> Middle Last <b>Steiner</b>			4. DATE OF DEATH Month <b>9</b> Day <b>11</b> Year <b>1960</b>			
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/1881</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mirror Glass Mfg.</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Herman Steiner</b>	13b. MOTHER'S MAIDEN NAME <b>Bertha Adler</b>	14. NAME OF HUSBAND OR WIFE <b>Sophie</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Sophie Steiner 468 Laurel Ave.</b>
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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>Coronary Embolism</b>		
DUE TO (b) <b>Arteriosclerotic heart disease</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <b>Generalized and cerebral arteriosclerosis</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>chronic brain syndrome due to cerebral arteriosclerosis</b>		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
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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.)
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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 checked="" 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
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21. I attended the deceased from <b>Aug. 12-1959</b> to <b>9-11-60</b> and last saw <b>him</b> alive on <b>9-11-60</b>
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Death occurred at <b>1:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Thomas J. Flynn</b>	22b. ADDRESS <b>1300 Grant Rd.</b>	22c. DATE SIGNED <b>9-11-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/13/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>	23d. LOCATION (City, town, or county) (State) <b>University City, Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Behger Memorial 4715 McPherson Avenue</b>	25. DATE RECD. BY LOCAL REG. <b>9-12-60</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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DOCUMENT Passport 3-2-39 MEDICAL CERTIFICATION BY AFFIDAVIT OF Funeral Director

SEP 21 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

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

Signed *Elvis G. Judson*

Licensed Embalmer No. 4229

P. O. Address \_\_\_\_\_

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.