

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040272

FILED VS 104 1960 318 Primary Registration District No. 1003 Registrar's No. 10397 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Lomay	
Length of stay in 1b 5-days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		d. STREET ADDRESS (If outside, give location) 3621 Bobring	
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 Middle Last Rose Steykosa			4. DATE OF DEATH Month Day Year Oct. 26, 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/24/73	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Miller County, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Williams		13b. MOTHER'S MAIDEN NAME Sarah ----		14. NAME OF HUSBAND OR WIFE Joseph Steykosa	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. L. A. Moushey - 3621 Bobring
-----------------------------------------------------------------------------------------------------------------	---------------------------------	---------------------------------------------------

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)	<i>Myocardial Decompensation</i>	<i>3 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Serility</i>	
	DUE TO (c) <i>434.4</i>	

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 checked="" 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 Month, Day, Year a.m. p.m.

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 *Jan 3, 1956* to *Oct 26, 1960* and last saw her *alive* on *Oct 25, 1960*
Death occurred at *8:00 A.* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>A Benjamin MD</i>	(Degree or title)	22b. ADDRESS <i>7430 Virginia Ave.</i>	22c. DATE SIGNED <i>10/26/60</i>
----------------------------------------	-------------------	-------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>Oct. 29, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Missouri Crematory</i>	23d. LOCATION (City, town, or county) STATE <i>St. Louis, Missouri</i>
---------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------------

24. FUNERAL DIRECTOR <i>WACKER-HELDERLE-3634 Gravois Ave.</i>	ADDRESS	25. REGISTRY LOCAL REG. <i>OCT 27 1960</i>	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>
------------------------------------------------------------------	---------	-----------------------------------------------	-----------------------------------------------------

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

Clarence M. Bill

Licensed Embalmer No. 4375

P. O. Address St. Louis 23. Mo.

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.