

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 5 1967 317

60-048376  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 500 Registrar's No. 3774

1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Missouri</b> , b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Affton (23)</b>		Length of stay in 1b <b>14 Years</b>		c. CITY OR TOWN <b>Affton (23)</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>7200 Aliceton Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7200 Aliceton Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>LESLIE</b> Middle <b>F.</b> Last <b>STEINBRECHER</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>2/2/95</b>	9. AGE (last birthday) <b>65</b>	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) <b>Office Work</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co. Gus Schroeder</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Robert Steinbrecher</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Koch</b>			14. NAME OF HUSBAND OR WIFE <b>Helen G. Steinbrecher</b>			
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>704-09-3651</b>		17. INFORMANT Address <b>Ave. (23)</b> <b>Helen G. Steinbrecher 7200 Aliceton</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>1 day</b>	
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 <b>1-8-54</b> to <b>12-28-60</b> and last saw him <sup>alive</sup> on <b>12-28-60</b> Death occurred at <b>5:00 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>W. H. Forman MD</b>				22b. ADDRESS <b>9501 Gravois</b>				22c. DATE SIGNED <b>12-29-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12/30/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis (20) Mo.</b>				
24. FUNERAL DIRECTOR <b>Fendler Und. Co. 7420 Michigan Ave.</b>			ADDRESS <b>(11)</b>		25. DATE RECD. BY LOCAL REG. <b>12-29-60</b>		26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. W. W. Foreman  
9505 Brown's Ave  
Fl. 3-1313

**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

*W. G. Peterson*

Licensed Embalmer No. 3767

P. O. Address 7420 Mi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.