

AMENDED FILED JUN 8 1961 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4925 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b	c. CITY OR TOWN <u>Clayton</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8125 Roxburgh Dr.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>SAMUEL</u> Last <u>STEINER</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>23</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Otto Steiner</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Oehler</u>		14. NAME OF HUSBAND OR WIFE <u>Etta Warren Steiner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Bert S. Steiner 5341 Loma Linda, Hollywood, Calif.</u>		

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) <u>BILATERAL HYDROTHORAX</u>		<u>1 MONTH</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CONGESTIVE HEART FAILURE</u>	<u>2-3 YEARS</u>
	DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u>	<u>5 1/2 YEARS</u>

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"/> N <input type="checkbox"/> Unknown	
---	--	---	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>8:55 P.M.</u> Month, Day, Year <u>JULY 7, 1944</u>	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 <u>St. Louis, Missouri</u>	COUNTY	STATE
---	--	--	--	--------	-------

21. I attended the deceased from <u>JULY 7, 1944</u> to <u>MAY 23, 1961</u> and last saw her/him alive on <u>MAY 23, 1961</u> Death occurred at <u>8:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>C. R. Luntton, M.D.</u> (Degree or title)	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>5/25/61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>	(State)
--	-----------------------------	---	---	---------

24. FUNERAL DIRECTOR <u>C. R. Luntton & Sons</u>	ADDRESS <u>7233 Delmar Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>W. J. Smith, M.D.</u>
---	-------------------------------------	--	---

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

STATE OF MISSOURI
DEPARTMENT OF HEALTH

NAME OF DECEASED _____ SEX _____ AGE _____

RESIDENCE OF DECEASED _____

DATE OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

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.