

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-010018

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 392 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 9 1962

VS 300  
Rev. 4/59

15117  
28140 2

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4 1

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123-0

131-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Des Moines</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Burlington</u>	
Length of stay in 1b <u>3 Months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>609 No. Gunnison</u>	
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) <u>ALPHARETTA STEINER</u>			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1962</u>
5. SEX <u>Female</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>1-6-1895</u>
9. AGE (last birthday) <u>67</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Warsaw, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Not Known</u>	
13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>James 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.	
17. INFORMANT <u>Mrs Harrie Jones Jr.</u>		Address <u>1604 1/2 St. Joe Ave.</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>Carcinomatosis</u>			<u>2 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of Colon</u>			<u>6 mo</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>			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 <u>5-17-60</u> to <u>4-3-62</u> and last saw her <u>alive</u> on <u>4-2-62</u> . Death occurred at <u>12:55a</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. Maginn</u> (Degree or title) <u>md</u>		22b. ADDRESS <u>702 Julia, St. Joseph, Mo</u>	22c. DATE SIGNED <u>4-3-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4-3-1962</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Burlington, Iowa.</u>
24. FUNERAL DIRECTOR <u>H.O. Sienfahn &amp; Son</u> ADDRESS <u>St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>April 3, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Standell</u>

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION  
R. Maginn M.D.

**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 Robert L. Gaylor

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.