

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9130

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2613

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Home for the Aged 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis 16  
(If outside city or town limits, write "RURAL")

(d) Street No. Home for the Aged  
3400 So. Grand Blvd.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME EDWARD STELLER

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 10 1861  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19th  
year 1940 hour 2 minute 35 P. M.

21. I hereby certify that I attended the deceased from Oct 15 to March 19, 1940  
that I last saw him alive on March 12, 1940  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>--</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Cerebr. Corded Cerebr. Sclerosis Duration 3 yrs

Due to Arteriosclerosis 4 yrs

Due to \_\_\_\_\_

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation File Cutter

Other conditions None  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Philip Steller ?

13. Birthplace Dont know. ?  
(City, town, or county) (State or foreign country)

14. Maiden name Magdalena Ebbe

15. Birthplace Dont know. ?  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Sister Seraphine  
(b) Address 3400 So. Grand Blvd.

17. (a) Burial (b) Date thereof Mar. 20, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SS. Peter & Paul

18. (a) Signature of funeral director J. H. Helken & Co.  
(b) Address 2842 Beramec St.

19. (a) March 19 1940 (b) J. F. Braddock  
(Date) (Signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. F. Braddock (M. D. or other) \_\_\_\_\_  
Address Union Club Bldg. Date signed 3/19/40

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**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 me

.....; Registered Apprentice No.....  
working under my personal supervision.

Signed Laron E. Percy

Licensed Embalmer No. 4094  
2842 Meramec St.  
P. O. Address..... St. Louis, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

## STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSState File No. 9130

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 2612

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution .....  
 (Specify whether  
 In this community .....  
 years, months or days)

3. (a) PRINT FULL NAME Edward Steiner

3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced .....  
 6. (b) Name of husband or wife ..... 6. (c) Age of husband, or wife, if alive ..... years  
 7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace ..... (City, town, or county) (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

12. Name .....

13. Birthplace ..... (City, town, or county) (State or foreign country)

14. Maiden name .....

15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....

(b) Address .....

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) NOV 19 1940 (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....  
 (c) City or town ..... (If outside city or town limits write "RURAL")  
 (d) Street No. .... (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? ..... years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 19-40  
 year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 .....  
 that I last saw h. .... alive on ..... 19 .....  
 and that death occurred on the date and hour stated above.

Immediate cause of death .....  
Arteriosclerosis  
Cerebral Sclerosis  
Cerebral arteriosclerosis  
Paralysis Agitans  
 Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death) \$712

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:  
Of operations .....

Of autopsy .....

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? ..... (Specify type of place) (c) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY

