

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 29 1943

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4060C
Registrar's No. 11150

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH BTS
(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: Josephine Heitkamp Hospital
(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)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County 17
(c) City or town St. Louis 915
(If outside city or town limits, write "RURAL")
(d) Street No. 3660a Marceline Terrace
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Margaret Steiner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day Saturday
year 1943 hour 9 minute P M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jauslin Steiner 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased March 30 1891
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 3, 1943 to Dec 9, 1943
that I last saw h. w alive on Dec 9, 1943
and that death occurred on the date and hour stated above.

8. AGE: Years 52 Months 8 Days 11 If less than one day _____ hr. _____ min.

Immediate cause of death Acute Myocarditis
Due to Fibroid of Uterus - non malignant
Due to _____

9. Birthplace Europe 4
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

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

11. Industry or business _____
12. Name John Heinz
13. Birthplace Europe 4
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.
Major findings: large Fibroid
Of operations _____
Of autopsy none

16. (a) Informant Jauslin Steiner
(b) Address 3660a Marceline Terrace
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/43
(Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus
18. (a) Signature of funeral director Wm. C. Maydell
(b) Address 1926 Allen Ave.
19. (a) DEC 15 1943 (Date received local registrar) (b) J. F. Brueck (Registrar's 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)
23. Signature Julius C. Roller (M.D. or other) M.D.
Address 2603 Cherokee St. Date signed 12/13/43

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

D. M. Davis

Licensed Embalmer No. 3741

P.O. Address 1926 Allen ave

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 this body is not embalmed, fact should be so stated above.