

FILED FEB 14 1944

State File No. _____

Registration District No. 132

Primary Registration District No. 3021

Registrar's No. 196

1. PLACE OF DEATH

(a) County Grundy
(b) City or town IRENTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WRIGHT Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community 80 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Grundy 40
(c) City or town Irenton 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1434 Chestnut
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME SARAH M. STECKMAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife E. H. Steckman 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased. Apr 30 1858
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Homemaker

11. Industry or business None

MOTHER FATHER { 12. Name Wesley C Mitchell
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth M. Adams
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Ella Steckman

(b) Address Irenton, Mo

17. (a) burial (b) Date thereof 1-4-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri County

18. (a) Signature of funeral director Samuel Davis

(b) Address Irenton Mo

19. (a) 1-6-44 (b) L. Roberts
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2nd
year 1944 hour 9:00 minute 8 M.

21. I hereby certify that I attended the deceased from Jan 1 43
19____ to Jan 2 1944

that I last saw her alive on Jan 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration 2 days

Due to Myxedema & Senility 10 yrs

Due to _____

Other conditions. (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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 DR. Brooks (M. D. or other) _____
Address Irenton Mo Date signed 1-5-44

MAR 12 1945

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.....
Myself, Registered Apprentice No.....
working under my personal supervision.

Signed

Raymond A. Davis

Licensed Embalmer No. *3424*

P. O. Address *Shelton, Mo.*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Trenton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wright Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 wk. (Specify whether
80 yr. years, months or days)

3. (a) PRINT FULL NAME

Sarah M. Steekman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased April 30 - 1913
(Month) (Day) (Year)

8. AGE: Years 85 Months 8 Days 20 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Hypotensive Preymin 2da.

Due to myelodema + skin 10/10/44

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major finding of operations Bronchial

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 JOR Rooks (M. D. or other) _____

Address Trenton Mo Date signed 2-12-44

SUPPLEMENTAL

MAR 18 1945

29660

JUL 18 1944