

FILED SEP 8 1944 318
Registration District No.

Primary Registration District No. 1003

State File No. _____
Registrar's No. 7013

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5933 Theodore Ave. /
(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:

(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 5933 Theodore Ave. (If rural, give location) 99
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Elizabeth Steiner

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

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

6. (b) Name of husband or wife Joseph Steiner 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Oct. 1, 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 20 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____

12. Name Henry Kober

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

14. Maiden name Ernestine Spitzberg

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

16. (a) Informant Joseph Steiner,
(b) Address 5933 Theodore Ave.

17. (a) Burial (b) Date thereof Aug. 27, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery
Bromschwig Und. Co.

18. (a) Signature of funeral director _____
(b) Address 4746 West Florissant Ave.

19. (a) J. F. Bredebeck (b) _____
(Date of local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25
year 1944 hour 2:20 AM minute _____ M.

21. I hereby certify that I attended the deceased from 1/6/44
_____ 19, to 8/25/44 19, _____
that I last saw her alive on 8/25/44
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral occlusion Duration 1 day

Due to _____

Due to _____

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

Major findings:
Of operations none

Of autopsy none

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. Bredebeck (M. D. or other) _____
Address 4707 W. Florissant Date signed 8/25/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Signed

E. W. Wilkins

Licensed Embalmer No.....

3575

P. O. Address.....

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.