

V. S. No. 2
100M-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U. S. STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

35887

State File No. 10190
Registrar's No. 10190

FILED DEC 7 1945
Registration District No. 318
Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County.....
(b) City or town..... St. Louis
(c) Name of hospital or institution: Barnes Hospital
(d) Length of stay: In hospital or institution 19 days
In this community 25 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Michael Steiner
3. (b) If veteran, name war None
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Theresa
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Apr. 10, 1885 (Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 15 If less than one day hr. min.

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

10. Usual occupation Forman

11. Industry or business

12. Name George Steiner

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

14. Maiden name Not known

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

16. (a) Informant Theresa Steiner

(b) Address R R 3 Box 39 Bellefontaine Rd

17. (a) Burial (b) Date thereof 11/23/45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethel

18. (a) Signature of funeral director Math. Hermann & Son

(b) Address 2161 East Fair Avenue

19. (a) NOV 26 1945 (Date received local registrar) J. J. Medeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 96
(c) City or town Bellefontaine Rd (If outside city or town limits, write "RURAL")
(d) Street No. R R 3 Box 39 (If rural, give location) NR?
(e) Citizen of foreign country? (Yes or No) If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 25 year 1945 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from 11-6 1945 to 11-25 1945 that I last saw him alive on 11-25 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Metastatic Carcinoma
Due to Ca. of Prostate
Other conditions (Include pregnancy within 3 months of death) 51

Major findings: Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Rd 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 FR Bradley (M. D. or other) Address Barnes Hospital, Date signed 11-25

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

APR 4 1944

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

Gustav W Dietrich

Licensed Embalmer No. *4329*

P. O. Address *St Louis, 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 this body is not embalmed, fact should be so stated above.