

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25320**
Registrar's No. **6235**

FILED JUL 30 1949

318

1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY Kath. Ste. Louis Inkrueger				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 1 day		c. CITY (If outside corporate limits, write RURAL and give township) Overland		09/6	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hosp.				4. STREET ADDRESS (If rural, give location) MIA - 3161 Ashby			
3. NAME OF DECEASED (Type or Print) a. (First) Katherine Steinkrueger			b. (Middle) _____			c. (Last) _____	
4. DATE OF DEATH July 17, 1949		5. SEX Fe.		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH Jan. 22 1902		9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		11. BIRTHPLACE (State or foreign country) St. Louis Co. Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Geo. Steinkrueger		13b. MOTHER'S MAIDEN NAME Katherine Schneider		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Ester Steinkrueger ADDRESS 3101 Ashby			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH 1940-1944 ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis 20 yrs or so DUE TO (c) upper respiratory & Toxicities II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension for fibroid 1947			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) Mo.		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4252					
22. I hereby certify that I attended the deceased from July 16, 1949 , to July 17, 1949 , that I last saw the deceased alive on July 16, 1949 , and that death occurred at 3:55 PM from the causes and on the date stated above.							
23a. SIGNATURE Mark J. Mason M.D. (Degree or title)				23b. ADDRESS 506 Oak St.		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 20 1949		24c. NAME OF CEMETERY OR CREMATORY St. Monica Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D. BY LOCAL REGISTRAR'S SIGNATURE J. B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS Ortmann Bldg. Home 9222 Oakland			

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *A. C. Ortman*

Licensed Embalmer No. 3478

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.