

FILED NOV 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **33107**

|  |                               |   |   |  |   |   |  |
|--|-------------------------------|---|---|--|---|---|--|
| BIRTH NO. _____  |                               | REG. DIST. NO. <u>42</u>  |   | PRIMARY REG. DIST. NO. <u>1000</u>   |   | Registrar's No. <u>1184</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Buchanan</u><br>b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Joseph</u> )<br>c. LENGTH OF STAY (In this place) <u>1 day</u><br>d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u> |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u><br>c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u><br>d. STREET ADDRESS (If rural, give location) <u>304 Victorian Court</u> |   |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Emma</u> b. (Middle) <u>Wilhelmina</u> c. (Last) <u>Steffens</u>  |                               | 4. DATE OF DEATH<br>(Month) (Day) (Year) <u>October 27, 1949</u>  |   |  |   |   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>   | 8. DATE OF BIRTH <u>August 28, 1907</u> | 9. AGE (In years last birthday) <u>42</u>  | IF UNDER 1 YEAR Months _____ Days _____   | IF UNDER 4 HRS. Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Armour &amp; Co.</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>Buchanan County, Missouri</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |
| 13a. FATHER'S NAME <u>William L. Steffens</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Emma L. Schmidt</u>  |   | 14. NAME OF HUSBAND OR WIFE <u>None</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>488-14-6574</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME <u>Miss. Gertrude Steffens</u> ADDRESS <u>St. Joseph, Mo.</u>  |   |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Asthma</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Cardiac Tachycardia</u> |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u><br><br><u>24 hr</u><br><u>20 hrs.</u> |  |
| 19a. DATE OF OPERATION _____   |                               | 19b. MAJOR FINDINGS OF OPERATION _____  |   |  | 20. AUTOPSY?<br>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)<br><u>St. Joseph Buchanan Mo</u>   |   |   |  |
| 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? _____   |   |   |  |
| 22. I hereby certify that I attended the deceased from <u>10-26, 1949</u> , to <u>10-27, 1949</u> , that I last saw the deceased alive on <u>10-27, 1949</u> , and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above.               |                               |   |   |  |   |   |  |
| 23a. SIGNATURE <u>T.R. Howden M.D.</u> (Degree or title)   |                               |   | 23b. ADDRESS <u>419 Kirkpatric</u>      |  | 23c. DATE SIGNED <u>10-28-49</u>  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 24b. DATE <u>Oct. 29, 1949</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>   |   | 24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>               |  |
| DATE REC'D BY LOCAL REG. <u>Nov 2, 1949</u>  |                               | REGISTRAR'S SIGNATURE <u>E. S. Jenkins</u> <u>382</u>   |   | FUNERAL DIRECTOR'S SIGNATURE <u>Walter Mierhoffer</u> ADDRESS <u>1046 Colhoun St. St. Joseph, Mo.</u>  |   |   |  |

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, ~~on~~ by \*\*\*\*\*

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\*\*\*\*

Student Embalmer No. \*\*\*\*\*

working under my personal supervision.

\*\* \*\*\*\*\*

Student .....

Student Embalmer

Signed

*Raymond H. Morehead*

Licensed Embalmer No. 4413 Missouri.

P. O. Address St. Joseph, Missouri.

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.