

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14780

State File No. 4085

FILED MAY 12 1951

318

1003

Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (In this place) 6 WKS.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	2059
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH HOSPITAL		d. STREET ADDRESS (If rural, give location) 762 HAMILTON	

3. NAME OF DECEASED (Type or Print) SIGMUND	a. (First)	b. (Middle)	c. (Last) STIEFFEL	4. DATE OF DEATH (Month) (Day) (Year) 4/29/1951
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1/24/1889	9. AGE (In years last birthday) 62	If UNDER 1 YEAR Months Days	If UNDER 10 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER	10b. KIND OF BUSINESS OR INDUSTRY UNIFORM Co	11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME RAPHAEL STIEFFEL	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE GERETA STIEFFEL
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME GERETA STIEFFEL	ADDRESS 762 HAMILTON
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Infarction DUE TO (c) Arteriosclerotic Coronary Artery disease		weeks years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H201
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22. I hereby certify that I attended the deceased from **4/24**, 19**51**, to **4/29**, 19**51**, that I last saw the deceased alive on **4/29**, 19**51**, and that death occurred at **11:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE Clara Brentbaum, M.D.	(Degree or title)	23b. ADDRESS 216 S. Kuegel Highway	23c. DATE SIGNED 4/30/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5/1/1951	24c. NAME OF CEMETERY OR CREMATORY BRITH SHOLEN	24d. LOCATION (City, town, or county) (State) UNIVERSITY CITY, Mo
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DATE REC'D BY LOCAL REG. MAY 1 1951	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE BERGER MEMORIAL	ADDRESS 4715 N. PIERSON
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

James A. Anderson

Signed

Student Embalmer

Licensed Embalmer No. 4229

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.