

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED DEC 17 1953

State File No. **44490**
Registrar's No. **11751**

V. S. No. 300
REV. 10-48

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 44490		Registrar's No. 11751		
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).						
a. COUNTY _____				a. STATE Missouri		b. COUNTY _____		c. CITY OR TOWN St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			• STREET ADDRESS (If rural, give location) 2159 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION 5310 Gilson Ave				• STREET ADDRESS (If rural, give location) 15 5310 Gilson Ave						
3. NAME OF DECEASED			4. DATE OF DEATH			(Month) (Day) (Year)				
a. (First) Robert			b. (Middle) _____			c. (Last) Steffel			12-11-1953	
5. SEX 6		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		White		Married		1-31-1895		58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)			12. CITIZEN OF WHAT COUNTRY?		
Maintenance Man			City of St. Louis		Kansas			U.S.A.		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Robert Steffel			Rose Panek			Theresia Steffel				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME					
No			494-36-4837		Theresia Steffel 5310 Gilson Ave					
18. CAUSE OF DEATH				MEDICAL CERTIFICATION						
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolus						
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES						
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						
				DUE TO (b) Rheumatic Heart Disease						
				DUE TO (c) _____						
				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 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?					
			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		416X					
22. I hereby certify that I attended the deceased from Aug 18, 1951, to Dec. 11, 1953, that I last saw the deceased alive on 10-10, 1953, and that death occurred at 5:15 A.M., from the causes and on the date stated above.										
23a. SIGNATURE				(Degree or title)			23b. ADDRESS		23c. DATE SIGNED	
Masao Okimoto				M.D.			607 N. Grand		12/11/53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)				
Burial		12-14-1953		St. Peter and Paul Cemetery		7030 Gravois Ave (State)				
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS
DEC 14 1953				J. Carl Smith			NO Egerman Bros.			6409 Gravois Ave
(Licensed Embalmer's Statement on Reverse Side)										

WRITE PLAINLY—USING UNFAADING 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.....
Signature of Student Embalmer

Signed.....
Van M. Simon

Licensed Embalmer No. *4343*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.