

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45459

STATE FILE NUMBER

292

FILED DEC 24 1957

Registration District No. 310 Primary Registration District No. 3058 Registrar's No.

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY Saint Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY OR TOWN Saint Charles (If outside corporate limits, give TOWNSHIP only)		c. CITY OR TOWN Saint Charles (If outside, give location)	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 700-a No. Third		d. STREET ADDRESS 700-a North Third	
3. NAME OF DECEASED First Frank Middle E. Last Steinmann		4. DATE OF DEATH Month Dec. Day 18, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY farming	9. AGE (In years last birthday) 76
13a. FATHER'S NAME Casper Steinmann		13b. MOTHER'S MAIDEN NAME Mary Schulte	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	14. NAME OF HUSBAND OR WIFE Annie Sommer
17. INFORMANT Mrs. F.E. Steinmann		Address St. Charles, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200			INTERVAL BETWEEN ONSET AND DEATH 8 to 10 hours
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from July, 1957 to Dec 18, 1957 and last saw ^{her} him alive on Dec 18, 1957 Death occurred at 10 30 a.m. 12/18/57 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Otto K. Thiele M.D.		22b. ADDRESS 300 N. Main - St Charles Mo.	22c. DATE SIGNED 12/20/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 21, 1957	23c. NAME OF CEMETERY OR CREMATORY Borrower Cemetery	23d. LOCATION (City, town, or county) (State) Saint Charles, Mo.
24. FUNERAL DIRECTOR D. C. Dallmeier		25. DATE RECD. BY LOCAL REG. Dec 20 57	26. REGISTRAR'S SIGNATURE Muellea Wilson

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

533
540
8

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 *Frank R. Amalony*
Licensed Embalmer No. *4830*
P. O. Address *St. Charles*

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.