Health, & Welfare Public Service

21
S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-026523
STATE FILE NUMBER

FILED JUL 16 1958 Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 108

1. PLACE OF DEATH
a. COUNTY PIKE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) LOUISIANA — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) PIKE CO. HOSPITAL — Length of stay in 1b 2 WEEKS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY PIKE
c. CITY OR TOWN CLARKSVILLE 0 — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) RFD 2 — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First August Middle WILLIAM Last STEINHAGE

4. DATE OF DEATH Month July Day 12 Year 1958

5. SEX MALE 0
6. COLOR OR RACE WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH OCT. 4, 1899
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY FARMER
11. BIRTHPLACE (City and state or country) TROY, ILL 1
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME AUGUST H. STEINHAGE
13b. MOTHER'S MAIDEN NAME DORA BRUNNWATER
14. NAME OF HUSBAND OR WIFE VERDIER STEINHAGE

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. 496-40-7904
17. INFORMANT MRS. AUGUST W. STEINHAGE, Address RFD CLARKSVILLE MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Metastasis — INTERVAL BETWEEN ONSET AND DEATH 6 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Malignant Lymphoscarcoma generalized — 9 years
DUE TO (c) 2001
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 1949, to 7-12-58 and last saw her/him alive on 7-11-58
Death occurred at 5:40 A.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Chas H Lumellen M.D.
22b. ADDRESS Louisiana, Mo
22c. DATE SIGNED 7-12-58

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 7/14/58
23c. NAME OF CEMETERY OR CREMATORY EOLIA CEMETERY
23d. LOCATION (City, town, or county) (State) EOLIA, MO.

24. FUNERAL DIRECTOR ADDRESS 2 TERNE FUNERAL HOME, LOUISIANA, MO.
25. DATE RECD. BY LOCAL REG. July 14-1958
26. REGISTRAR'S SIGNATURE Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

SEP 18 1958

AUG 22 1958

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 Virginia Dare Estabrook

Licensed Embalmer No. 4645

P. O. Address Louisiana, 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.