

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046369
STATE FILE NUMBER

FILED JAN 14 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12243

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|---|----------------------------------|---|--|
| 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, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | d. STREET ADDRESS (If outside, give location) 38 N. Central | |
| 3. NAME OF DECEASED (Type or print) First Marvin Middle Ernest Last Stiegman | | 4. DATE OF DEATH Month December Day 17 Year 1958 | |
| 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 January 15, 1911 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Trucks | 11. BIRTHPLACE (City and state or country) Montgomery Co., Mo. |
| 13a. FATHER'S NAME Fredrick E. Stiegman | | 13b. MOTHER'S MAIDEN NAME Annie Norman | 14. NAME OF HUSBAND OR WIFE Alida Stiegman |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 514-05-7142 | 17. INFORMANT Address Mrs. Alida Stiegman, 38 N. Central |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Coronary Sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 420.1 DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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 _____ to _____ and last saw her/him alive on _____ Death occurred at 1155A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Catriek Taylor Carauer | | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 12.18.58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12-18-58 | 23c. NAME OF CEMETERY OR CREMATORY Local | 23d. LOCATION (City, town, or county) (State) Montgomery City, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. DEC 18 '58 | 26. REGISTRAR'S SIGNATURE Carl Smith MD mab |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 17 1959

FEB 9 1959

APR 1 1959

APR 2 1959

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 *Robert M. Murra*

Licensed Embalmer No. *37491*
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.