

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025959

FILED JUL 16 1959 209

Primary Registration District No. 3043 Registrar's No. 200

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>MARION</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>IOWA</b> b. COUNTY <b>LEE</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HANNIBAL</b>		Length of stay in 1b		c. CITY OR TOWN <b>MONTROSE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LEVERING HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>PEGGY JEAN STEINMANN</b>				4. DATE OF DEATH Month Day Year <b>JUL 4 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>12-23-29 29</b>	9. AGE (last birthday) <b>29</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hannibal Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Raymond Dryden</b>			13b. MOTHER'S MAIDEN NAME <b>Lora Mason</b>		14. NAME OF HUSBAND OR WIFE <b>Harlan R. Steinmann</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>49 98 9069</b>		17. INFORMANT Address <b>Harlan R. Steinmann Montrose Iowa</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contusion &amp; Edema of Lungs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>60 Hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO <b>Contusion &amp; Cloudy Swelling of Kidneys</b> <b>60 Hrs</b> <b>Fracture of bodies 8th 10th 12th thoracic Vertebra</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>Unknown</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Fell or Jumped from second floor window</b>				
20c. TIME OF INJURY Hour a.m. <b>6:45 AM</b>	Month, Day, Year <b>Jul 2 59</b>	while emotionally upset.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Levering Hospital</b>		20f. CITY, TOWN, OR LOCATION <b>Hannibal</b>		COUNTY <b>Marion</b>	STATE <b>Missouri</b>
21. I attended the deceased from <b>June 20 - 59</b> to <b>July 4 59</b> and last saw her alive on <b>July 4 59</b> Death occurred at <b>6:40PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>J. E. Sultzman M.D.</b>				22b. ADDRESS <b>Hannibal Mo</b>		22c. DATE SIGNED <b>7-7-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7-7-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hannibal Ralls Missouri</b>			
24. FUNERAL DIRECTOR <b>Smith's Funeral Home Hannibal Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>July 9 - 1959</b>	26. REGISTRAR'S SIGNATURE <b>H. E. Lucke By H. C. Fisher</b>		

DOCUMENT

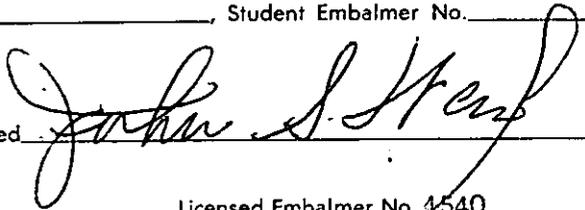
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_  
Licensed Embalmer No. 1540

P. O. Address Hannibal, Miss.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.