

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038112

FILED VS OCT 23 1959

2 9394

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

UNRECORDED

| | | | |
|--|--|---|--|
| 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 | | Length of stay in 1b 50 yrs | c. CITY OR TOWN St. Louis 4425 Tholozan Avenue |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 4425 Tholozan Avenue |

| | | | | | |
|---|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) First MATHILDA Middle STEDING Last | | | 4. DATE OF DEATH Month Oct. Day 11 Year 1959 | | |
| 5. SEX female | 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 10/14/1891 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (City and state or country) St. Marys, Missouri | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Tripp (adopted name) Schneider | | 13b. MOTHER'S MAIDEN NAME unknown | | 14. NAME OF HUSBAND OR WIFE Otto F. Steding | |

| | | |
|---|-------------------------|--|
| 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. | 17. INFORMANT Mr. Otto F. Steding, 4425 Tholozan Ave |
|---|-------------------------|--|

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Intestinal obstruction | | 2 weeks |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) adeno-carcinoma of sigmoid (colon) | 2 months |
| | DUE TO (c) 153.3 | |

| | |
|---|---|
| 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 type="checkbox"/> NO <input checked="" type="checkbox"/> | 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 **9/30/59** to **10/11/59** and last saw her alive on **10/11/59**
Death occurred at **12:25 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--|--|
| 22a. SIGNATURE (Degree or title) B. W. Klippel, M.D. | 22b. ADDRESS 3701 Grandel Sq. St. Louis, Mo. | 22c. DATE SIGNED 10/12/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE Oct. 14, 1959 | 23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery |
| | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri |

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave | 25. DATE RECD. BY LOCAL REG. OCT 13 '59 | 26. REGISTRAR'S SIGNATURE Carl Smith, M. |
|--|---|--|

m. p. B.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. B. W. Klippel
3701 Grandel Sq.

2-4 PM

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 C Russell

Licensed Embalmer No. 4570

P. O. Address Atlanta

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.