

URJ DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

79-039804

FILED VS DEC 14 1959

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. \_\_\_\_\_ Registrar's No. 303

ENDED

1. PLACE OF DEATH a. COUNTY <u>Henry Co.</u> <u>Miller's Rest Home</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Windsor, Mo.</u> Length of stay in 1b _____		c. CITY OR TOWN <u>Montrose</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>(above)</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>in Montrose</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Mi</u> Last <u>Steinbach</u>			4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>59</u>		
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5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-1876</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Svenin Staff</u>	13b. MOTHER'S MAIDEN NAME <u>Barbara S</u>	14. NAME OF HUSBAND OR WIFE <u>Bert Steinbach</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>John Steinbach</u> Address <u>Windsor, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Gen. Arteriosclerosis w/ Art. Ht. Dis.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Nil</u> <u>2-3 yrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (g) <u>total Blindness</u>		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
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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.) _____
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20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____ Month, Day, Year _____
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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.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
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21. I attended the deceased from <u>9-21-59</u> to <u>12-4-59</u> and last saw her <u>alive</u> on <u>12-4-59</u> Death occurred at <u>8:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Doctor or title) <u>Clude M. Thurber MD</u>	22b. ADDRESS <u>Windsor, Mo</u>	22c. DATE SIGNED <u>12-6-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-7-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	23d. LOCATION (City, town, or county) (State) <u>Montrose Mo</u>
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24. FUNERAL DIRECTOR <u>Sickman-Dunning</u> ADDRESS <u>Clinton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 7, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 me  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Robert J. Dunn

Licensed Embalmer No. 4310

P. O. Address Clinch

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.