

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FEB 25 1960

2 1866

STATE FILE NUMBER  
60-008921

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4408 Beck Ave.</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>C.</u> Last <u>STEEPIG</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-1914</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Treloar, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>August E. Haase Sr.</u>			13b. MOTHER'S MAIDEN NAME <u>Lydia Begemann</u>			14. NAME OF HUSBAND OR WIFE <u>John Steppig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>497-05-9290</u>		17. INFORMANT Address <u>John Steppig 4408 Beck Ave.</u>			
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>Brain metastasis of cancer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Carcinomatosis</u>						<u>10 days</u>	
DUE TO (c) <u>Inflammatory Cancer right breast</u>						<u>3 Mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>170+</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	
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"/>	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 <u>February 3, 1959</u> to <u>February 15, 1960</u> and last saw her <u>February 15, 1960</u> Death occurred at <u>5:00 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Curtis A. Truier, M.D.</u>				22b. ADDRESS <u>4952 Maryland Ave. St. Louis</u>		22c. DATE SIGNED <u>2/16/60</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Feb. 19, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lucas Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>		
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>				25. DATE RECD. BY LOCAL REG. <u>FEB 17 1960</u>	26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u> <u>mdc</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2-25-51 60

**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 William B. White

Licensed Embalmer No. 4281

P. O. Address 422 8th St

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