S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED NOV 19 1945

STANDARD CERTIFICATE OF DEATH

State File No. 35885

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9582

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis Mo.
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days (Specify whether)
In this community (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Macoupin 999
(c) City or town Mt. Olive 11
(If outside city or town limits, write "RURAL")
(d) Street No. NR 02
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Herman Edward Steinbach

3. (b) If veteran, name war Nil
3. (c) Social Security No. 346-07-3367

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Susan Steinbach
6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased July 7 1901 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
44	3	28	hr. min.

9. Birthplace St. Louis Missouri 0 (City, town, or county) (State or foreign country)
10. Usual occupation Baker
11. Industry or business
FATHER
12. Name August Steinbach
13. Birthplace Leibsik Germany 4 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Louise Decker
15. Birthplace St. Louis Missouri 0 (City, town, or county) (State or foreign country)
16. (a) Informant August Steinbach, Sr.
(b) Address Mt. Olive, Ill.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-6-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive, Illinois
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) NOV 5 1945 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 5 year 1945 hour 8 minute 25 A.M.
21. I hereby certify that I attended the deceased from 10-17 1945 to 11-5 1945
that I last saw him alive on 11-5 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death shock	
Due to Gastrointestinal hemorrhage	2 days
Due to Chronic myelogenous leukemia	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Enlarged spleen and liver, bone marrow infiltration	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature F. R. Bradley (M. D. or other)
Address Barnes Hospital Date signed 11-5-45

(Licensed Embalmer's Statement on Reverse Side)

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 ....

...., Registered Apprentice No.......................................,

working under my personal supervision.

Signed G. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address..

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 this body is not embalmed, fact should be so stated above.