

No. 2
243
5-17-39
X35697

FILED SEP 15 1946

Primary Registration District No. 3010

Registrar's No. 296

1. PLACE OF DEATH:

(a) County CAPE GIRARDEAU
(b) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. FRANCIS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 DAYS (Specify whether years, months or days)
In this community 27 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County CAPE GIR.
(c) City or town CAPE GIRARDEAU
(If outside city or town limits, write "RURAL")
(d) Street No. 151 So BOULEVARD
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME LEO PAUL STEIMLE

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JAN - 16 - 1894
(Month) (Day) (Year)

8. AGE: Years 52 Months 7 Days 18 If less than one day hr. _____ min. _____

9. Birthplace KELSO, MO
(City, town, or county) (State or foreign country)

10. Usual occupation ASSESSOR

11. Industry or business CAPE GIR. Co.

12. Name CHARLES STEIMLE

13. Birthplace GERMANY

14. Maiden name KATHERINE HOFFLER

15. Birthplace SCOTT CO. MO.
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. LEO STEIMLE

(b) Address CAPE GIRARDEAU.

17. (a) BURIAL (b) Date thereof 9-4-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW LORIMIER GEM

18. (a) Signature of funeral director Walthus Und. Co.

(b) Address Cape Girardeau Mo

19. (a) 9-7-1946 (b) G. G. Summer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4 year 1946 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from Sept 2 1946 to Sept 4 1946 that I last saw him alive on Sept 4 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial thrombosis Duration _____

Due to Obstr. Myocardite 3
Due to Endocardite 4yo.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Myocarditis & thrombosis Underline the cause of death should be stated statistically.
Of operations _____
Of autopsy ✓

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? ✓

While at work? ✓ (Specify type of place) (e) Means of injury _____

23. Signature W. H. Shellen (M. D. or other) MS

Address Cape Girardeau Date signed 9/4/46

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

MOTHER FATHER

ADDITIO...
STATISTICAL...
REQUESTED

44

4
946-2590
9-9-46

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 *Virgil H. Kelch*
Licensed Embalmer No. *4102*
P. O. Address *Cape Girardeau, Mo.*

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.

Oct

Registration District No.

5

Primary Registration District No.

3010

Registrar's No.

296

1. PLACE OF DEATH:

(a) County *Cape Girardeau*
(b) City or town *Cape Girardeau*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)

In this community years, months or days

3. (a) PRINT FULL NAME

Leo Paul Steinfeld

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex *m*

5. Color or race *w*

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased

Jan 10 1940
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

52

7

mo

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Sept* year *1940* hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from *9* to *10*, 19*40*;

that I last saw him *alive* on *Sept 10*, 19*40*;

and that death occurred on the date and hour stated above.

Immediate cause of death

mesenteric thrombosis

Due to *Gangrene of ileocolic and cecum & sigmoid*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature *H Washburn* (M. D. or other) *MD*

Address *Cape Girardeau MO* Date signed *10-9-40*

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

28609

SUPPLEMENTARY

29773