

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

92  
MAR 1 1935

1. PLACE OF DEATH Emmaus Home

County St. Charles

Registration District No. 757

Township St. Charles

Primary Registration District No. 5998

City St. Charles

(No. Emmaus Home)

File No. 2609

Registered No. 3

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Bertha Eliza Steiner

(a) Residence, No. EMMAUS HOME St. \_\_\_\_\_ Ward. California, Missouri  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 6 mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 18, 1880</u>		
7. AGE <u>54</u>	YEARS <u>1</u>	MONTHS <u>17</u>
DAYS <u>17</u>		If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
	10. Date deceased last worked at this occupation (month and year) _____
	11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)

13. NAME Jacob Steiner

14. BIRTHPLACE (CITY OR TOWN) Switzerland  
(STATE OR COUNTRY)

15. MAIDEN NAME Mrs. Meiers

16. BIRTHPLACE (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)

17. INFORMANT Rev. Storker  
(ADDRESS) St. Charles, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE California, Mo. DATE 1-5, 1935

19. UNDERTAKER Steinbrinker Furniture Co.  
(ADDRESS) 504 North Main

20. FILED 15 1935 Clarence A. Hensley  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 5, 1935

22. I HEREBY CERTIFY That I attended deceased from Jan. 4, 1935 to Jan. 5, 1935

I last saw him alive on Jan. 4, 1935. Death is said

to have occurred on the date stated above, at 3:20 A.M.

The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_

Cerebral Hemorrhage due to Fracture Skull 48 hrs.

Other contributory causes of importance: Cretinism Epilepsy

Name of operation No Date of \_\_\_\_\_

What test confirmed diagnosis? Signs & Symptoms Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? No Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? St. Charles, Mo.  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

In home, during Epileptic attack

Manner of injury \_\_\_\_\_

Nature of injury Fracture skull

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

(Signed) A. P. Emil Schurz M. D.

(Address) St. Charles, Mo.

