

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

PLACE OF DEATH Saline
County Saline
Township Colony
or
Village
or
City (NO. _____ St.: _____ Ward)

Registration District No. 794 File No. 4071
Primary Registration District No. 6037A Registered No. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME William Steffen

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH Mar 25, 1868
(Month) (Day) (Year)

AGE 51 yrs. 10 mos. 27 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farming

BIRTHPLACE (City or town, State or foreign country) West Glasgow Mo

PARENTS
NAME OF FATHER Chas Steffen
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Rosa Malka
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kathryn Steffen
(ADDRESS) William 112

Filed Jun 19, 1920 REGISTRAR W. D. Durrison

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 19, 1920
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 9, 1920, to June 19, 1920 that I last saw him alive on June 18, 1920 and that death occurred, on the date stated above, at 6:20 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Peptic Ulcer

170 (Duration) 4 yrs. 1 mos. 1 ds.

Contributory none
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) W. D. Durrison M. D.
June 19, 1920 (Address) Glasgow Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Washington Cemetery Glasgow Mo DATE OF BURIAL Jun 21, 1920

UNDERTAKER Ed Wenger ADDRESS Glasgow Mo

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____ (Write the word)	SINGLE MARRIED WIDOWED OR DIVORCED
DATE OF BIRTH _____	(Month) _____ (Day) _____ (Year) _____	
AGE _____	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION _____
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____
 (City or town, State or foreign country)

NAME OF FATHER _____
 BIRTHPLACE OF FATHER _____
 (City or town, State or foreign country)

MAIDEN NAME OF MOTHER _____
 BIRTHPLACE OF MOTHER _____
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____, 191____
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death, _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? _____
 Former or usual residence. _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____