PLACE OF DEATH

County *Saline*

Township *Cambridge* or Village ______ or City ______ (NO. ______ St.; ______ Ward)

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

Registration District No. *794* File No. 4071

Primary Registration District No. *6032A* 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	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	*W*	*Married*

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 *Cora Molke a*

BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Germany*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Kathren Steffen*

(ADDRESS) *Gilliam Mo*

Filed *Jun 17, 1920* *J. H. Davidson* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Jun 19, 1920* (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Jun 4*, 1920, to *Jun 19*, 1920, that I last saw h*im* alive on *Jun 18*, 1920, and that death occurred, on the date stated above, at *6-20 a*.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

131

140

(Duration) *4* yrs. *0* mos. *0* ds.

Contributory (SECONDARY) *None*

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) *J. H. Davidson* M. D.

Jun 19, 1920 (Address) *Gilliam 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 Wengler*

ADDRESS *Glasgow Mo*

PLACE OF DEATH

County_____

Township _____
or
Village_____
or
City _____ (NO._____, _____ St.; _____ Ward)

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

Registration District No._____ File No._____

Primary Registration District No._____ Registered No._____

[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	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day) 1_____ (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)

PARENTS

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

_____, 191__
(Month) (Day) (Year)

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:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)_____ M. D.

_____, 191__ (Address)_____

*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	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS