

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

Do not use this space.

11126

1. PLACE OF DEATH

County Callaway
Towship Fuller
City Fuller (No. _____)

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 76
St. _____ Ward _____

2. FULL NAME

Robt St Steen

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 6 da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Mrs. R. H. Steen

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

no information

7. AGE

YEARS MONTHS DAYS
69 | no information | _____
If LESS than 1 day, _____ hrs. _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 2

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) America

10. NAME OF FATHER

no information

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) no information

12. MAIDEN NAME OF MOTHER

no information

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) no information

14.

INFORMANT Hospital Records
(Address) Fuller Mo

15.

FILED 4/23/27 1927 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-23-1927

17. I HEREBY CERTIFY That I attended deceased from Feb 27 1927 to Apr 23 1927 that I last saw him alive on Apr 23 1927, and that death occurred, on the date stated above, at 8:45 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Broncho Pneumonia
10:15 (duration) _____ mos. 6 da.

CONTRIBUTORY (SECONDARY)

chronic interstitial nephritis (duration) _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: 129 A

DID AN OPERATION PRECEDE DEATH? No DATE _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. P. Frazier M. D.

4-23-1927 (Address) Fuller Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Vandalia, Mo.

DATE OF BURIAL

D.K. 19 _____

20. UNDERTAKER

Hirndon-Taylor Furn-Co.

ADDRESS

Fulton, Mo.

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.

