

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

Do not use this space.

5716

1. PLACE OF DEATH
 County Cape Girardeau Registration District No. 124
 Township Ward Primary Registration District No. 4070 File No. _____
 City Jackson (No. _____) St. _____ Ward _____ Registered No. 12

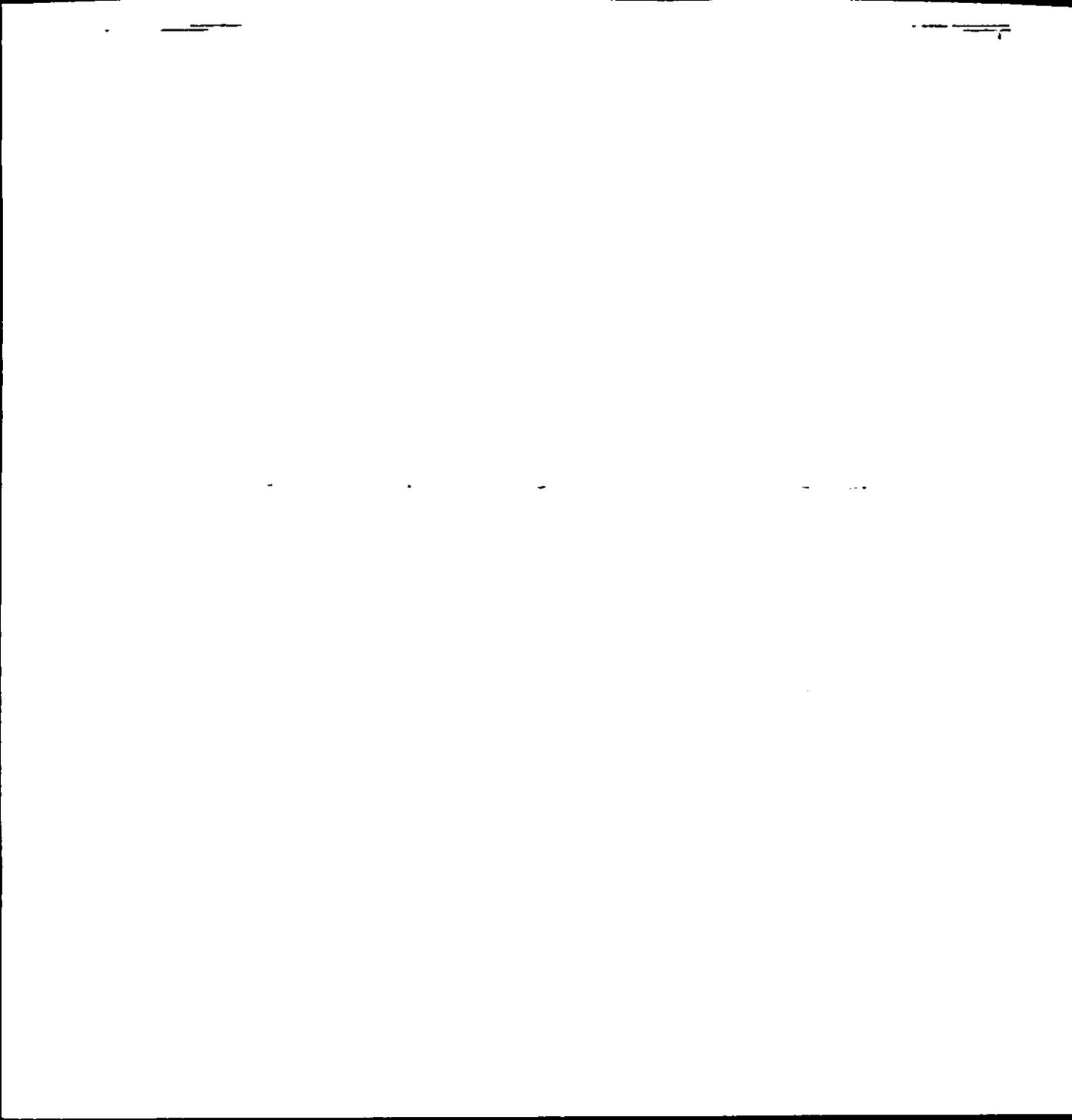
2. FULL NAME Christian Stein
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Catherine Rakowski Stein
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 21st - 1825
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
103 8 24
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
 10. NAME OF FATHER Unknown Stein
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 14. INFORMANT H. F. Seimers
 (Address) Jackson, Mo.
 15. FILED 2-14-29 D. G. Subar REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1929
 17. I HEREBY CERTIFY That I attended deceased from Feb 12 1929 to Feb 14 1929
 that I last saw him alive on Feb 14 1929 and that death occurred, on the date stated above, at 10:15 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Thrombosis
92 D
III B
 (duration) yrs. mos. 3 da.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.
 18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) C. A. Lofgren, M. D.
2-14, 1929 (Address) Jackson 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 Lorimer Cem. DATE OF BURIAL Feb 17, 1929
 20. UNDERTAKER Walther Und Co ADDRESS Cape Girardeau, Mo.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Casey Registration District No. 124 File No. _____
 Township _____ Primary Registration District No. 4070 Registered No. 12
 City Jackson (No. _____) St. _____ Ward _____

2. FULL NAME Christian Stein
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
--------	-------	--------	------	--

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

PARENTS

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 4-11-29 D. G. Sibus REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 14 1929

17. I HEREBY CERTIFY that I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Pulmonary Edema
& Acute myocardial infarction
 (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
9008
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) _____, M. D.
 . 19 _____ (Address) _____

*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 _____	DATE OF BURIAL _____ 19____
20. UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SSS