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

Do not use this space.

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1. PLACE OF DEATH
County Crawford
Township Oak Hill
City Cuba (No. ..... , ... St. ..... Ward)

Registration District No. 230
Primary Registration District No. ~~5313~~ 414

File No. .....
Registered No. .....

2. FULL NAME Henry Eberhardt 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. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-18-1892

7. AGE YEARS 41 MONTHS 1 DAYS 26 If LESS than 1 day, ... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

FATHER
13. NAME Conrad Stein
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

MOTHER
15. MAIDEN NAME Helen Koeln
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

17. INFORMANT (ADDRESS) Anna Stein Cuba Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Pleasant Point DATE 1-17-1934

19. UNDERTAKER (ADDRESS) Elbert E Long Cuba Mo

20. FILED Feb 1st 1934 G. G. A. Fessog Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/14/, 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan. 10/ 1934, to Jan 14, 1934
I last saw h— alive on Jan 12, 1934. Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

Tuberculosis

Date of onset

Other contributory causes of importance:

Lobar Pneumonia

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) W. G. Anderson, M. D.
(Address) Cuba 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.

WHITE PLANET, HIGH UNFADING INK—THIS IS A PERMANENT RECORD

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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

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Crawford

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Henry Eberhardt Stein

Who died at _____ on Jan 14 / 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W ~~Single~~, married, ~~widowed or divorced~~: _____

Date of birth _____ Age: Years 41 Months 1 Days 26

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Tuberculosis

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Lobar Pneumonia Primary
Tuberculosis of Lungs Secondary

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

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

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician W. G. Henderson

Address of physician Cuba, Mo

Signature of Registrar Dr G. G. A. Herzog Date filed Sept 24/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 230

Primary Reg. Dist. No. 4140

E. T. McGaugh
Special Agent. M. D.

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