S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 14 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31786

Registration District No. 20-061 Primary Registration District No. 3041 Registrar's No. 242.

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: Macon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Samaritan
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Macon 61
(c) City or town: Macon 3
(If outside city or town limits, write "RURAL")
(d) Street No. 2
(If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William F. Steine
3. (b) If veteran, name war: Spanish-american
3. (c) Social Security No.
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Lizzie Steine
6. (c) Age of husband or wife if alive: 69 years
7. Birth date of deceased: May (Month) 3 (Day) 1870 (Year)

8. AGE: Years	Months	Days	If less than one day
77	4	22	hr. min.

9. Birthplace: Michigan (City, town, or county) (State or foreign country) 1
10. Usual occupation: Retired Farmer
11. Industry or business
MOTHER FATHER
12. Name: Charles S. Steine
13. Birthplace: Michigan (City, town, or county) (State or foreign country) 1
14. Maiden name: Rosetta Darrow
15. Birthplace: Michigan (City, town, or county) (State or foreign country) 1
16. (a) Informant: Mrs Lizzie Steine
(b) Address: Bevier Mo RR 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Unionville Cemetery
18. (a) Signature of funeral director: M. L. Edwards
(b) Address: Bevier Mo
19. (a) 10/10/47 (Date received local registrar) (b) Ruth McNeely (Registrar's signature) 85

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 25 year 1947 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from Apr 1947 to Sept 25 1947 that I last saw him alive on Sept 25 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis with decompensation — Duration: Sev. yrs. 2 wks.
Due to:
Due to:
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations: N/B
Of autopsy:

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: [illegible] (M. D. ~~or other~~)
Address: Macon Date signed 10/9/47

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-47-1412
OCT 13 1947
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Registered Apprentice No. ....., working under my personal supervision.

Signed [illegible]

Licensed Embalmer No. 1961

P. O. Address Bowie Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.