

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

Do not use this space.

1717

1. PLACE OF DEATH

County Jackson
Towship Plan
City Kansas City (No. Kansas City Gen Hospital)

Registration District No. 399

Primary Registration District No. 1002

File No. _____
Registered No. 509
St. _____ Ward _____

2. FULL NAME

Steiner, A. J.
(a) Residence. No. 3816 E. 18 St., 11 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (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. Emma W. Steiner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 12, 1870

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	58	5	8	

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

9. BIRTHPLACE (CITY OR TOWN) Munich
(STATE OR COUNTRY) Germany

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Germany

14. INFORMANT Reed Clark
(Address) Kansas City Gen Hosp.

15. FILED 1-21-29 M. M. Cox REGISTRAR

2) MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-20-1929

17. I HEREBY CERTIFY, That I attended deceased from 1-17-1929, to 1-20-1929
that I last saw him alive on 1-20-1929, and that death occurred, on the date stated above, at 1100 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral thrombosis
87A

CONTRIBUTORY (SECONDARY) Hypertension
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED At home
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) P. E. Williams, M. D.
1-20, 1929 (Address) Sup's K.B. Gen Hosp

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Crementation DATE OF BURIAL Jan. 27, 1929

20. UNDERTAKER Reuman Mortuary ADDRESS 104 W. 42nd St.

M. 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MAR 2 1954