

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

Do not use this space.

14618

1655

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 1655  
 Township Rand Primary Registration District No. 1002 Registered No. \_\_\_\_\_  
 City W.C. Mo. (No. W. Garfield Hospital St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Herman Steckling  
 (a) Residence. No. 3707 Paue St. 13 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 (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louise Steckling  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 65  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Retired Baker  
 (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) Missouri

10. NAME OF FATHER Albert Steckling

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Margdaline Oreck

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Germany

14. INFORMANT Lloyd J. Steckling (Address) 3707 Paue avy

15. FILED 4/5 1929 M. M. Crowe asst. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 4 1929  
 17. Doan I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, at \_\_\_\_\_, m.  
 death occurred, on the date stated above, at \_\_\_\_\_, m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Throat Cancer, By Throat  
Arteriosclerosis  
 195 (duration) yrs. mos. da.  
 CONTRIBUTORY (SECONDARY) 198 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? yes  
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
 (Signed) Shaney M. Hall, M. D.  
4/4 1929 (Address) deputy corner

\*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 mt. Moriah DATE OF BURIAL Apr. 6, 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS W.C. 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.

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

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