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

7441
Do not use this space.

FEB MAR 12 1940

1. PLACE OF DEATH
(a) County Monteau
(b) Township Linn
or
(c) City
Registration District No. 574
Primary Registration District No. 4338
Registered No.
(d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lydia Anna Steines
(a) Residence, No. Jamestown Mo 5 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
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 William Godfra Steines
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 24 1880
7. AGE Years 59 Months 8 Days 18 If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home wife
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Jamestown O

FATHER
13. NAME John Roesche
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

MOTHER
15. MAIDEN NAME Catherine Schroeder
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

17. INFORMANT (ADDRESS) William G. Steines Jamestown Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Jamestown DATE Feb 14 1940
19. FUNERAL DIRECTOR (NAME) Charles Fullrich
(ADDRESS) Jamestown Mo
20. FILED Feb 12 1940 Abe Oren Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-12 1940
22. I HEREBY CERTIFY, That I attended deceased from 1-29 1940 to 2-12 1940
I last saw her alive on 2-12 1940 Death is said to have occurred on the date stated above, at 8 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chr Valvular	
Disease of Heart	Antecedent
9 Yr	
Other contributory causes of importance:	
Arterio Sclerosis	Antecedent

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) O L Meredith M. D.
(Address) Francis House Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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.

50M-9-19-38 I X16605

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 N. E. Friedmeyer

Licensed Embalmer No. 2854

P. O. Address California 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, above space should be left blank.

No. 2B
—2-21-40
X22859

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7441

Registration District No. 574 Primary Registration District No. 4338 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Monteau
(b) City or town Jamestown
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lydia Anna Steiner
3. (b) If veteran name war Wm Go
3. (c) Social Security No.
4. Sex
5. Color or race
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Wm Godfrey Steiner
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased May (Month) 24 (Day) 1846 (Year)

8. AGE: Years 69 Months 8 Days 18 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant Wm G. Steiner
(b) Address Jamestown Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 12 year 1920 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to 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

23. Signature G. L. Meredith (M.D.) (Coroner)
Address Prairie Home Date signed