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

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

PLACE OF DEATH

County Cole

Township Moreau or Village or City

Registration District No. 214 File No. 61 27255

Primary Registration District No. ~~4130~~ 5294 Registered No. 61

(NO. St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Fritz Diederich Steffens

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | COLOR OR RACE: White | SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word): Married

DATE OF BIRTH: March (Month) 2 (Day), 1841 (Year)

AGE: 78 yrs. 6 mos. 13 ds. | If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Germany

PARENTS

NAME OF FATHER: Donit Senou

BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

MAIDEN NAME OF MOTHER: Donit Senou

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo N Steffens

(ADDRESS) Russellville Mo

Filed Sept 16th 1919. Hugh L Cordon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: September (Month) 15 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 12, 1919, to Sept 16, 1919, that I last saw h[illegible] alive on Sept 15, 1919, and that death occurred, on the date stated above, at 11½ m.

The CAUSE OF DEATH* was as follows:

Paralysis (Apoplexy)

64 (Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) [illegible]

(Duration) yrs. mos. ds.

(Signed) W. L. Leslie M. D.

Sept 16, 1919 (Address) Russellville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Evangelical Cemetery	Sept 17th 1919

UNDERTAKER: Joseph B Barnett ADDRESS: Healdsburg California

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

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

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory.....
(SECONDARY)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS