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

Do not use this space.

1398

399

1. PLACE OF DEATH
County Jackson Registration District No. 1002 File No. 390
Township Kaw Primary Registration District No. General Hospt Registered No.
City Kansas City (No. St. Ward)

2. FULL NAME Robert Steiner
(a) Residence. No. 2829 Askew St., 14 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	wh	Single

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 6, 1914

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
15	1	19	

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ill.

PARENTS
10. NAME OF FATHER Robt R. Steiner
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Bertha A Peter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT Robt R Steiner
(Address) 2829 Askew

15. FILED 1/27, 1930 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1930

17. Deputy Coroner
I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 2:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
accidental automobile transection
210M
1 212M
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Ran into auto while sleighing
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? History & Inspection
(Signed) Stanley McKee, M. D.
1/25, 1930 (Address) Deputy Coroner

*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 California, Mo DATE OF BURIAL Jan 28 1930

20. UNDERTAKER D. W. Newcomer's Sons ADDRESS K 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.

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[redacted]

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County .... Registration District No. 399 .... File No. ....

Township K-City .... Primary Registration District No. 1002 .... Registered No. 390

City .... (No. .... St. .... Ward)

2. FULL NAME Robert Steiner

(a) Residence. No. .... St., ... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 1/27 1930 M. M. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1930

17. I HEREBY CERTIFY, That I attended deceased from ...., 19...., to ...., 19...., that I last saw h.... alive on ...., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental automobile
traumatism
K C Mo
(duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) Ran into auto while sleighing (duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? .... DATE OF ....
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

188 C
219

(Signed) ...., M. D
, 19 (Address)

*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	DATE OF BURIAL
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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.

REG...S SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE ...

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