MAY 28 1927

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

Do not use this space.

12330

File No.

Registered No. 169

1. PLACE OF DEATH

County Marion Registration District No. 547

Township ~~Mason~~ Primary Registration District No. 3029

City Hannibal (No. , Lovering Hospital St. 6 Ward)

2. FULL NAME Henry Edward Stein

(a) Residence. No. 305 A. So. Main St., 3 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| Male | White | Single |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 22 1872

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 54 K | 6 | 9 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Hannibal

(STATE OR COUNTRY) Marion Co. Mo.

PARENTS

10. NAME OF FATHER Henry J. Stein

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Annie Washendofer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hannibal

(STATE OR COUNTRY) Marion Co. Mo.

14. INFORMANT Mrs. Annie Stein

(Address) 305 A. So. Main Hannibal, Mo.

15. FILED 4/8 1927 C E Strode REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 1 1927

17. I HEREBY CERTIFY, That I attended deceased from Mar 16, 1927, to Apr 1, 1927, that I last saw him alive on Apr 1, 1927, and that death occurred, on the date stated above, at 2:15 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Manic Depressive Psychosis

Duration

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? at home

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? General Symptoms

(Signed) C L Shinkle, M. D

(Address) Hannibal Mo 4-7-1927

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Olivet

DATE OF BURIAL 4/4 1927

20. UNDERTAKER Wm M. Smith

ADDRESS Hannibal 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.