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.

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

PLACE OF DEATH

County Gasconade.

Township Richland.

or Village

or City (NO. St.; Ward)

Registration District No. 304

Primary Registration District No. 5426

File No. 12819

Registered No. 10

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

FULL NAME Henry Braun.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	married

DATE OF BIRTH: Jan. (Month) 30 (Day), 1830 (Year)

AGE: 80 yrs. 4 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

(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: Not Known.

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) Fred Braun.

(ADDRESS) Potedam Mo.

Filed May 15, 1910. F. H. Caughell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 11 (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 5, 1910, to May 11, 1910, that I last saw h~~im~~ alive on May 1, 1910, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

Gr P

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

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

(Signed) F. H. Caughell M. D.

May 12, 1910 (Address) Morrison

*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: Catholic Cemetery Morrison

DATE OF BURIAL: May 12 1910

UNDERTAKER: Chas F. Poke.

ADDRESS: Morrison Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

HUGH STEPHENS, JEFFERSON CITY.

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

PLACE OF DEATH

County Gasconade

Township Richland

or Village ~~Bernadotte~~ Mo

or City

Registration District No. 304 File No. 1

Primary Registration District No. 5421 Registered No. 10

(NO. St.; Ward)

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

FULL NAME Henry Braun

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: Jan (Month) 30 (Day), 1830 (Year)

AGE: 80 yrs. 4 mos. 10 ds. If LESS than 1 day; hrs. or min.?

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

(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: Not Known

BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

MAIDEN NAME OF MOTHER: Not Known

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Braun

(ADDRESS) Potsdam Mo

Filed May 15 1910. F H Campbell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 11 (Day), 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 5, 1910, to May 11, 1910, that I last saw h[illegible] alive on May 1, 1910, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) F H Campbell M. D.

May 12 1910. (Address) Morrison

*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
Catholic Cemetery Morrison	May 12 1910
UNDERTAKER	**ADDRESS**
Christ F Pope	Morrison Mo

N. B.—Every item of information should be carefully considered before answering. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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_____

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

...d be stated EXACTLY. PHYSICIANS should state ...ified. Exact statement of OCCUPATION is very important.