

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 Warren
Township Bridgeport
or
Village _____
or
City _____ (No. _____ St. _____ Ward _____)

Registration District No. 881 File No. 33072

Primary Registration District No. 6172 Registered No. 41

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

FULL NAME

Mary Brucke Hoff

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH _____
(Month) 7 (Day) 25 (Year) 1910

AGE _____ yrs. 2 mos. 21 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE (City or town, State or foreign country) Case, Mo.

PARENTS
NAME OF FATHER John Brucke Hoff
BIRTHPLACE OF FATHER (City or town, State or foreign country) Waineland Missouri
MAIDEN NAME OF MOTHER Mary Engeman
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marthasville, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Brucke Hoff
(ADDRESS) Case, Missouri

Filed Oct 21st 1910 Anton Bail REGISTRAR
Sub.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month) 10 (Day) 20 (Year) 1910

I HEREBY CERTIFY, that I attended deceased from Oct 15, 1910, to Oct 20, 1910, that I last saw her alive on Oct 19, 1910, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
marasmus

11 mos
15 ds (Duration) yrs. 2 mos. 21 ds.

Contributory Indigestion
(SECONDARY) (Duration) 2 yrs. 2 mos. 21 ds.

(Signed) James T. Leslie M. D.
Oct 21, 1910 (Address) McTearick

*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 St Anthony cemetery DATE OF BURIAL Oct 22, 1910

UNDERTAKER John Weber ADDRESS Case, 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*, *Composer*, *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*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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 septicæmia," "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.)



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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County Warren
Township or Village or City Bridgeport

Registration District No. 881 File No. _____
Primary Registration District No. 6172 Registered No. 41

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

FULL NAME Mary Brueckerhoff (NO. _____ St. _____ Ward _____)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OF RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single
DATE OF BIRTH 7 29 910 (Month) (Day) (Year)
AGE 2 mos. 21 ds. If LESS than 1 day, ____ hrs. or ____ min.?

DATE OF DEATH _____, 1910
I HEREBY CERTIFY, that I attended _____, that I last saw him alive on Oct. 14, 1910, and that death occurred, on the date stated above, at 9 1/2 m.

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

The CAUSE OF DEATH was as follows:
Stroke

BIRTHPLACE (City or town, State or foreign country) Case, Mo.

Contributory (Secondary) Indigestion (Duration) 2 mos. 21 ds.

PARENTS
NAME OF FATHER John Brueckerhoff
BIRTHPLACE OF FATHER (City or town, State or foreign country) Princeton, Missouri
MAIDEN NAME OF MOTHER Mary German
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marionville, Mo.

(Signed) James J. Leslie M. D. (Address) Mr. Kottick
Oct 21 1910

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Brueckerhoff
(ADDRESS) Case, Missouri

*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 _____

Filed Oct 21 1910 W. H. Moore REGISTRAR

PLACE OF BURIAL OR REMOVAL St. Anthony Cemetery DATE OF BURIAL Oct. 22, 1910
UNDERTAKER John Heber ADDRESS Case, Mo.

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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