

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County St. Louis
Township St. Ferdinand
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 784 File No. 35447

Primary Registration District No. 6030 Registered No. 238

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

FULL NAME Louisa Baumgardt

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov. 4, 1910
(Month) (Day) (Year)

AGE 53 yrs. 7 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) St. Louis Co.

PARENTS
NAME OF FATHER Peter Jacob Baumgardt
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Steidorn M.D.
(ADDRESS) Bridgeport Mo

Filed Nov 9 1910 J. Y. Douglas REGISTRAR
W. F. Steidorn

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 4, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March, 1910, to Nov. 4, 1910, that I last saw her alive on October 10, 1910, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

131
(Duration) 15 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. F. Steidorn M. D.
Nov. 4, 1910 (Address) Bridgeport 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 Wetstone Mo R.R. 28

PLACE OF BURIAL OR REMOVAL Over Coeur DATE OF BURIAL Nov. 6, 1910

UNDERTAKER Baumgardt ADDRESS Over Coeur

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 septicaemia," "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.)



MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County St. Louis
Township St. Ferdinand
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 784 File No. 35447
Primary Registration District No. 6020 Registered No. _____

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

FULL NAME Louisa Baumgarth

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Nov. 4, 1885
(Month) (Day) (Year)
AGE 55 yrs. 7 mos. 21 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer) House keeping institution

BIRTHPLACE (City or town, State or foreign country) St. Louis Co.

PARENTS NAME OF FATHER Peter Jacob Baumgarth BIRTHPLACE OF FATHER Bernhard
MAIDEN NAME OF MOTHER Katharina De Krause BIRTHPLACE OF MOTHER Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant) W. H. Heicher M.D. (ADDRESS) Brighton, Mo.

Filed Jan 7, 1910 Registrar J. Y. Douglas

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 4, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from March 18, 1909 to Nov. 4, 1910, that I last saw her alive on Oct 15, 1910, and that death occurred, on the date stated above, at 2:30 p.m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration) 15 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) W. H. Heicher M. D.
114, 1910 (Address) Brighton

*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 Hester, Mo. N. W. 28

PLACE OF BURIAL OR REMOVAL Crematorium DATE OF BURIAL 1/6, 1910
UNDERTAKER Bourmann Crem Co ADDRESS _____

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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