

RECORDS DEPARTMENT, WITH UNFOLDING 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.

PLACE OF DEATH

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

County Cape Girardeau
Township Apple Creek
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 128 File No. 544
Primary Registration District No. 5176B Registered No. 2

FULL NAME "Un-named" Fromberger
(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Caucasian SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Jan 18th, 1911
(Month) (Day) (Year)
AGE _____ yrs. _____ mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Jan 23, 1911
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from Jan 20, 1911, to Jan 23, 1911, that I last saw him alive on Jan 22, 1911, and that death occurred, on the date stated above, at 5th m.
The CAUSE OF DEATH* was as follows:

BIRTHPLACE Apple Creek, Mo
(City or town, State or foreign country)

"Convulsions"
1 hr. - 10 min.
2 yrs. _____ mos. _____ ds.
Contributory Menigeal hemorrhage
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

PARENTS
NAME OF FATHER Albert Fromberger
BIRTHPLACE OF FATHER Oakridge, Mo
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Schrida Sawyer
BIRTHPLACE OF MOTHER Apple Creek, Mo
(City or town, State or foreign country)

(Signed) W. C. Statter M. D.
Jan 23, 1911 (Address) Oakridge, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

*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 _____

(ADDRESS) _____
Filed Jan 23, 1911 H. B. Fitchell
REGISTRAR

PLACE OF BURIAL OR REMOVAL Thomas Cross
DATE OF BURIAL Jan 23, 1911
UNDERTAKER H. B. Williams
ADDRESS Oak Ridge 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 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.)



PLACE OF BIRTH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

County Cape Girardeau
 Township Apple Creek
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 128
 Primary Registration District No. 5176B

File No. 544
 Registered No. 2

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

FULL NAME "Un named" Growa barger

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>M</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>1-18-11</u> <small>(Month) (Day) (Year)</small>		
AGE <u>5</u> <small> yrs. mos. ds. or min.?</small>		
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		

DATE OF DEATH _____, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1-20, 1911, to 1/23, 1911, that I last saw alive on 1/22, 1911, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:
Convulsions

BIRTHPLACE
Apple Creek Mo
(City or town, State or foreign country)

PARENTS	NAME OF FATHER <u>Albert Tombarge</u>
	BIRTHPLACE OF FATHER <u>Paris Mo</u> <small>(City or town, State or foreign country)</small>
	MAIDEN NAME OF MOTHER <u>Schuldes Sawyer</u>
	BIRTHPLACE OF MOTHER <u>Apple Creek Mo</u> <small>(City or town, State or foreign country)</small>

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory meningial hemorrhage
(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W.R. Statter M. D.
1/23-1911 (Address) Oakridge 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Albert Tombarge
 (Informant)

(ADDRESS) Oakridge Mo

PLACE OF BURIAL OR REMOVAL
Thomas Cem -

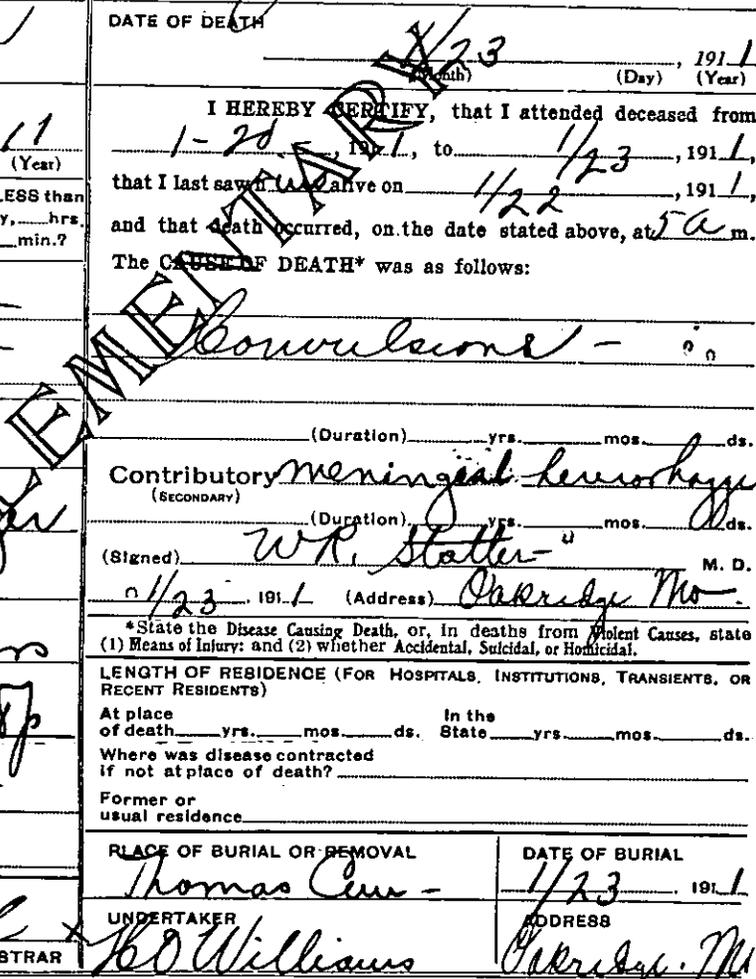
DATE OF BURIAL
1/23-1911

UNDERTAKER
Ed Williams

ADDRESS
Oakridge Mo

Filed Jan 24 1911 by H B Pettrell REGISTRAR

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.



JAN

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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