

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

PLACE OF DEATH
County Marion
Township _____
or
Village _____
or
City Hamburg (NO. 423 Madison St.: 4 Ward)

Registration District No. 547 File No. 7105
Primary Registration District No. 3029 Registered No. 43

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

FULL NAME Chas. H. Schuman

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>Oct 18, 1849</u> (Month) (Day) (Year)		
AGE <u>61</u> yrs. <u>3</u> mos. <u>22</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Painter</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>503</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>		
PARENTS	NAME OF FATHER <u>Unknown</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>"</u>	
	MAIDEN NAME OF MOTHER <u>"</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>"</u>	

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH <u>Feb 9, 1911</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>Dec 19, 1910</u> , to <u>Feb 9, 1911</u> , that I last saw him alive on <u>Feb 8, 1911</u> , and that death occurred, on the date stated above, at <u>5:58</u> m.
The CAUSE OF DEATH* was as follows: <u>Tuberculosis, General</u> <u>320</u> <u>-1230</u>
(Duration) yrs. <u>8</u> mos. _____ ds.
Contributory (SECONDARY) <u>Rectal fistula</u> (Duration) yrs. <u>60</u> mos. _____ ds.
(Signed) <u>J. J. Bourne</u> M. D. <u>79</u> (Address) <u>Hamburg, Mo.</u>

*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
(Informant) Frank Schuman
(ADDRESS) Hamburg Mo.
Filed Feb 9, 1911 A. SCHEINEMAN, X
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Madison</u>	DATE OF BURIAL <u>Feb 12, 1911</u>
UNDERTAKER <u>Ed. Dorrell, Prop.</u>	ADDRESS <u>Hamburg</u>

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 DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Madison
Township _____
or
Village _____
or
City Stannibal (NO. 423 Madison)

Registration District No. 547 File No. 7105
Primary Registration District No. 3029 Registered No. _____
St. 4" Ward

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

FULL NAME Chas. H. Schumm

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____ (Month) Feb 9 (Day) _____ (Year) 1911

DATE OF BIRTH Oct-18 (Month) 1849 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 19, 1910, to Feb-8, 1911, that I last saw alive on Feb-8, 1911, and that death occurred, on the date stated above, at 550d. m. The CAUSE OF DEATH* was as follows:

AGE 61 yrs. 3 mos. 22 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

Tuberculosis, general.
(Duration) _____ yrs. 8 mos. _____ ds.

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

Contributory Rectal Fistulae (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) Germany

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

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

(Signed) J. J. Bourne M. D. 2/9 1911 (Address) Hannibal, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) W. H. Schumm

Where was disease contracted If not at place of death? _____ Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Mt Olive DATE OF BURIAL Feb 12 1911

UNDERTAKER Doornall Bros. Hannibal ADDRESS _____

Filed _____ 1911 REGISTRAR _____

SUPPLEMENTARY

EB

Revised United States Standard Certificate of Death

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

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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.)