

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

PLACE OF DEATH
County St. Francois
Township _____
or _____
Village _____
or _____
City Farmington Mo (NO. _____ St. _____ Ward _____)

120
Registration District No. 773 File No. 7753
Primary Registration District No. 4464 Registered No. 13

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

FULL NAME Ann Krause

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH _____, 1839
(Month) (Day) (Year)
AGE 71 yrs. 11 mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 5-01

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

PARENTS
NAME OF FATHER Don't Know
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Don't Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. P. Krause
(ADDRESS) Crocker Mo

Filed 2/10/1911 C. R. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2 9, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2-4, 1911, to 2-9, 1911, that I last saw him alive on Oct 9th, 1911, and that death occurred, on the date stated above, at 9:25 am. The CAUSE OF DEATH* was as follows:

uraemia
137 B
54
(Duration) _____ yrs. _____ mos. 5 ds.
Contributory Dementia
(Secondary) (Duration) 1 yrs. _____ mos. _____ ds.
(Signed) H. Lloyd M. D.
2-9, 1911 (Address Farmington 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. 4 mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? Crocker Mo
Former or usual residence Crocker Mo.

PLACE OF BURIAL OR REMOVAL Crocker Mo. DATE OF BURIAL _____, 1911

UNDERTAKER Thomas Long ADDRESS Farmington

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.

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

County St. Francis

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

Township _____

Registration District No. 773

File No. 7753

Village _____

Primary Registration District No. 4464

Registered No. _____

City Farmington Mo (NO. _____)

St. _____ Ward _____

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

FULL NAME Wm. Krause

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 1839
(Month) (Day) (Year)

AGE 71 yrs. 11 mos. ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

NAME OF FATHER Dont know

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

MAIDEN NAME OF MOTHER Dont know

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Krause

(ADDRESS) Crocker Mo.

Filed 2/10/11 W. C. R. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2-9, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from 2-4, 1911, to 2-9, 1911, that I last saw him alive on Feb-9th, 1911, and that death occurred, on the date stated above, at 9:25 a.m.

The CAUSE OF DEATH* was as follows: Uraemia

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (SECONDARY) Dementia
(Duration) 1 yrs. _____ mos. _____ ds.

(Signed) H. Lloyd M. D.
2-9, 1911 (Address) Farmington, 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. 4 mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? Crocker Mo.

Former or usual residence Crocker, Mo

PLACE OF BURIAL OR REMOVAL

Crocker, Mo

DATE OF BURIAL

2/10, 1911

UNDERTAKER

Thomas Long

ADDRESS

Farmington

Revised United States Standard Certificate of Death

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

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