

Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Phelps
Township Cold Springs Registration District No. 679 File No. 11556
or
Village _____ Primary Registration District No. 5907 Registered No. _____
or
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Antonia Holub

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OF RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(If wife the word)

DATE OF DEATH 2 10 1911
(Month) (Day) (Year)

DATE OF BIRTH June 30 1894
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Albany, Mo., 4/19/11, to 2-10, 1911,
~~that I last saw him alive on _____, 1911~~
had no medical attention
and that death occurred, on the date stated above, at _____ m.

AGE 77 yrs. 7 mos. 20 ds.
If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows: Unknown
died suddenly after slight ill-
ness as above stated. Declined
medical attention.

OCCUPATION
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

above stated, referred to
undertaker by Anton Holub,
Contributory and of deceased
(SECONDARY)
(Signed) [Signature] (Address) _____ M. D.
_____, 1911

BIRTHPLACE
(City or town, State or foreign country) Austria, Hungaria

NAME OF FATHER Martin Holub

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

MAIDEN NAME OF MOTHER Honey

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Antonia Holub, Jr.

(ADDRESS) Rolla, Mo.

Filed mar 22 1911 Joseph Williams
REGISTRAR

*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 Prayer Cemetery DATE OF BURIAL 2/12 1911

UNDERTAKER H. B. McCann ADDRESS Rolla, 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*, *peritonaeum*, 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 septichaemia," "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.)



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CERTIFICATE OF DEATH

PLACE OF DEATH

County Phelps
Township Cal Springs
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 679 File No. 11536
Primary Registration District No. 5907 Registered No. _____

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

FULL NAME

Anton Holm

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH June 30, 1834
(Month) (Day) (Year)

AGE 77 yrs. 7 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Austria, Hungaria

NAME OF FATHER Martin Holm

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

MAIDEN NAME OF MOTHER Haney

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Anton Holm Jr.
(ADDRESS) Rolla Mo

Filed X 191 Frank C. Groves REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 10, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased ^{was} ~~from~~ ill from Feb 4, 1911, to Feb 10, 1911, that I last saw h. alive on, 1911, he had no medical attendance and that death occurred, on the date stated above, at 12.15 p.m.

The CAUSE OF DEATH* was as follows: Unknown. Died suddenly after slight ill-
ness as above stated - Declined
medical attention.

above stated (Cause) furnished to me essential
by Anton Holm, son of deceased
Contributory
(SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.
_____, 1911 (Address) _____

*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 Beaver Cemetery DATE OF BURIAL Feb 12, 1911

UNDERTAKER H. R. McGaw ADDRESS Rolla Mo

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]

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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.)

