

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

PLACE OF DEATH

County Laclede
Township Lockwood
or Village Lockwood
or City Lockwood (NO. _____ St.: _____ Ward)

Registration District No. 238 File No. 17349
Primary Registration District No. 4145 Registered No. 18

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

FULL NAME Irene Lesette Bartling

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(If file the word)

DATE OF BIRTH Jan. 25th 1910
(Month) (Day) (Year)

AGE 1 yrs. 3 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 0

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 13, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 20, 1911, to May 13, 1911, that I last saw her alive on May 13, 1911, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

109A 97
152B

(Duration) ___ yrs. ___ mos. 23 ds.

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

PARENTS

NAME OF FATHER Louis H Bartling
BIRTHPLACE OF FATHER Neominden Ills.
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Alvina H Bartling
BIRTHPLACE OF MOTHER Addicksville Ills.
(City or town, State or foreign country)

Contributory Pneumonia, Abscess
(SECONDARY) (Duration) ___ yrs. ___ mos. 10 ds.

(Signed) J. J. Mackay M. D.
May 14, 1911 (Address) Lockwood

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis H Bartling
(ADDRESS) Lockwood 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 _____

Filed May 13, 1911 D Russell Mo
REGISTRAR

PLACE OF BURIAL OR REMOVAL Lockwood DATE OF BURIAL 5-18 1911
UNDERTAKER H G Caldwell ADDRESS Lockwood 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.)

HUGH STEPHENS, JEFFERSON CITY.



PLACE OF DEATH

County Wade

Township _____
 or
 Village _____
 or
 City Rockwood (NO. _____)

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 238 File No. _____

Primary Registration District No. 4145 Registered No. 18

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

FULL NAME Brene Lettice Barthig

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Single
(If wife the word)

DATE OF BIRTH 1-25-1910
(Month) (Day) (Year)

AGE 1 yrs. 3 mos. 18 ds. If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Rockwood, Ill.

PARENTS
 NAME OF FATHER Louis H. Barthig
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Rockwood, Ill.
 MAIDEN NAME OF MOTHER Albena W. Barthig
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Adrianville, Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Louis H. Barthig
 (ADDRESS) Rockwood, Ill.

Filed May 14 1911 by Russell Smith
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 5-13-1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4-20, 1911, to 5-13, 1911, that I last saw hu alive on 5-13, 1911, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
90
Pneumonia.

(Duration) yrs. _____ mos. 23 ds.

Contributory (SECONDARY) Pneumonia Abscess

(Duration) yrs. _____ mos. _____ ds.
 (Signed) J. J. Masey M. D.
5-14 1911 (Address) Rockwood

*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 Rockwood DATE OF BURIAL 5-14-1911

UNDERTAKER H. G. Caldwell ADDRESS Rockwood, Ill.

Original file, date 5-14 1911 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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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.)

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