

Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Bollinger
Township Liberty
Village _____
City _____

67
99
1026
940

Registration District No. 940 File No. 1 20319
Primary Registration District No. 5104 Registered No. 1
(NO. _____ St. _____ Ward _____)

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

FULL NAME Margarete Henninger

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED OR DIVORCED Single
(Write the word)
DATE OF BIRTH May 15, 1911
(Month) (Day) (Year)
AGE 7 yrs. 28 mos. 28 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE (City or town, State or foreign country) Bollinger Co

PARENTS
NAME OF FATHER Aug Henninger
BIRTHPLACE OF FATHER (City or town, State or foreign country) Bollinger Co
MAIDEN NAME OF MOTHER Francis Weber
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bollinger Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Henninger
(ADDRESS) Leopold
Filed June 14, 1911 J. M. Crimney Jr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY that I attended deceased from June 13, 1911, to June 27, 1911, that I last saw her alive on June 25, 1911, and that death occurred, on the date stated above, at 110 m.

The CAUSE OF DEATH* was as follows:
Inflammation of bowels
1170 104

Contributory (SECONDARY) not known
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Crimney Jr M. D.
June 14, 1911 (Address) Whitenaker 220

*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 _____ DATE OF BURIAL _____ 1911

UNDERTAKER _____ ADDRESS _____

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....(NO.....)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

St.....Ward.....

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
	DATE OF BIRTH	(Month).....(Day).....(Year)
AGEyrs.....mos.....ds.	If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION

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

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed.....

19.....

REGISTRAR

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

**Revised United States Standard Certificate
of Death**

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

coma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms).....

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month).....

I HEREBY CERTIFY, that I attended

....., 19....., to.....

that I last saw him.....alive on.....

and that death occurred, on the date stated

The CAUSE OF DEATH* was as follows:

(Duration).....yrs.....

Contributory

(SECONDARY)

(Duration).....yrs.....

(Signed).....

19.....

(Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTES, AND RECENT RESIDENTS).....

At place of death.....yrs.....mos.....ds. State.....yrs.....

Where was disease contracted if not at place of death?

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

DATE

UNDERTAKER

ADDRESS

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

County Bollinger
 Township Liberty
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 940 File No. 20319
 Primary Registration District No. 5104 Registered No. 1

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

FULL NAME Margerete Nemminger

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

DATE OF BIRTH May 15, 1911
 (Month) (Day) (Year)

AGE 7 mos. 28 ds. IF LESS than 1 day, ___ hrs. or ___ min. ?

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

BIRTHPLACE (City or town, State or foreign country) Bollinger Mo.

PARENTS NAME OF FATHER Aug. Nemminger BIRTHPLACE OF FATHER (City or town, State or foreign country) Bollinger Mo. MAIDEN NAME OF MOTHER Francis Lieber BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bollinger Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) August Nemminger (ADDRESS) Leopold

Filed June 19 1911 J. M. Finney Jr. REGISTRAR

Original file, date June 19 1911

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from June 13, 1911, to June 27, 1911, that I last saw her alive on June 25, 1911, and that death occurred, on the date stated above, at 11 P.m.

The CAUSE OF DEATH* was as follows: Inflammation of bowels

(Duration) ___ yrs. ___ mos. ___ ds. Contributory (SECONDARY) not known (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. M. Finney Jr. M. D. June 20 1911 (Address) Whitewater 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 _____

PLACE OF BURIAL OR REMOVAL Leopold Mo DATE OF BURIAL June 14 1911 UNDERTAKER Mrs Wurn ADDRESS Whitewater Mo

SUPPLEMENTARY

This form is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death. It is very important that the information given is correct. Exact statement of OCCUPATION is very important.

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]]

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 septicæmia," "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.)