

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

PLACE OF DEATH

County Franklin

Township Union

Village _____

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 296

File No. 24269

Primary Registration District No. 5413

Registered No. _____

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

FULL NAME Catherine Johnson

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov 8, 1923
(Month) (Day) (Year)

AGE 88 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

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

NAME OF FATHER Frederick Niemeyer

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

MAIDEN NAME OF MOTHER Lawson

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Johnson

(ADDRESS) 3101 Cass Ave

St Louis MO

REGISTRAR EA Sullivan

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 16, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 1st, 1911, to July 16, 1911, that I last saw her alive on July 15, 1911, and that death occurred, on the date stated above, at 942 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

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

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

(Signed) E A Sullivan M. D.
July 16, 1911 (Address) Union 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 Evangelical Cemetery DATE OF BURIAL July 18, 1911

UNDERTAKER Wm H Hume ADDRESS Union Mo

Filed July 17, 1911

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*, *Compositor*, *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.)



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

County Franklin Registration District No. 296 File No. _____
 Township Union or _____ Primary Registration District No. 5413 Registered No. _____
 Village _____ or _____ City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Catherine Lehman

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov. 8, 1823
 (Month) (Day) (Year)

AGE 88 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired
 (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 Frederick Meyer
 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) Fred Lehman
 (ADDRESS) 3101 Cass Ave

Filed July 21, 1911, Ca. Juntreg
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 16, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1911, to July 16, 1911,
 that I last saw her alive on July 15, 1911,
 and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Bronchitis

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

(Signed) E. A. Juntreg M. D. (Address) Union Mo.
July 16, 1911

*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 Evangelical Cem. DATE OF BURIAL July 18, 1911

UNDERTAKER Wm. H. Ham ADDRESS Union Mo.

Original file, date July 21, 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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