

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City St. Louis(NO. 1961 Sample Ave St. 27 Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 791 File No. 30077Primary Registration District No. 1003 Registered No. 7329

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

FULL NAME Hellen Krallmann

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)DATE OF BIRTH Aug 6, 1911
(Month) (Day) (Year)AGE _____ yrs. _____ mos. 16 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) St. Louis Mo

NAME OF FATHER

Norman B. Krallmann

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Ark.

MAIDEN NAME OF MOTHER

Anna Schroeder

BIRTHPLACE OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norm B. Krallmann(ADDRESS) 1961 Sample AveFiled AUG 23 1911 Max B. Starkloff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 22, 1911
(Month) (Day) (Year)I HEREBY CERTIFY that I attended deceased from Aug 22, 1911, to Aug 22, 1911, that I last saw him alive on Aug 22, 1911, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Stomach
1180
86
(Duration) _____ yrs. _____ mos. 7 ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. 1 ds.(Signed) C. E. Aldenderfer M. D.Aug 22, 1911 (Address) 2407 Wren

*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

Always to

UNDERTAKER

John Nash Son Lolo 4650 Easton Ave

DATE OF BURIAL

Aug 23, 1911

ADDRESS

4650 Easton Ave

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 _____

Township _____

or _____

Village _____

or _____

City _____

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 991

File No. _____

Primary Registration District No. 1003Registered No. 7829(NO. 1961 Sample Ave. St. 27 Ward)

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

FULL NAME Keller Krollman

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE N. SINGLE MARRIED WIDOWED OR DIVORCED 1
(Write the word)DATE OF BIRTH 8-6-94
(Month) (Day) (Year)AGE _____ yrs. _____ mos. 16 ds. If LESS than 1 day, _____ hrs. or _____ min. 2OCCUPATION (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) St. Louis, Mo.NAME OF FATHER Herman B. KrollmanBIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis, Mo.MAIDEN NAME OF MOTHER Wanda SchneiderBIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman B. Krollman(ADDRESS) 1961 Sample Ave.Filed Oct 7, 1941 A. G. Snodgrass REGISTRAROriginal file date Aug., 1941

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-22, 1941
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from 8-22, 1941, to 8-22, 1941, that I last saw him alive on 8-22, 1941, and that death occurred, on the date stated above, at 90 m.

The CAUSE OF DEATH* was as follows:

Gastritis

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

Contributory Catarrhal Gastritis
(SECONDARY)

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

(Signed) C. E. Krollman M. D.
8-22, 1941 (Address) 2407 W. 11th

*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 ChristyDATE OF BURIAL 8-23, 1941UNDERTAKER Mr. Kroll + Son ADDRESS 4657 Main Ave

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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