

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

PLACE OF DEATH

County Oade
Township Grant
or
Village
or
City 1- (NO. _____ St.: _____ Ward)

Registration District No. 238 File No. 34137
Primary Registration District No. 5327 Registered No. 26

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

FULL NAME Elizabeth Koelliker

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb. 2, 1891
(Month) (Day) (Year)

AGE 80 yrs. 8 mos. 6 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Milweil Switzerland

PARENTS
NAME OF FATHER Stephen Koelliker
BIRTHPLACE OF FATHER (City or town, State or foreign country) Milweil Switzerland
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Switzerland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Conrad Wood
(ADDRESS) Golden City Mo.

Filed Oct 9, 1911 D Russell M D REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 8, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 6, 1911, to Oct 3, 1911, that I last saw her alive on Oct 3, 1911, and that death occurred, on the date stated above, at 6-9 a.m.

The CAUSE OF DEATH* was as follows:

Fractured Femur
16611
1943 185
1539 (Duration) yrs. 1 mos. 3 ds.
Contributory Decubitus
(SECONDARY) (Duration) yrs. ___ mos. 15 ds.

(Signed) B. A. Wilson M. D.
Oct 8, 1911 (Address) Golden City 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 Kistler Cem. Dade Co. Mo DATE OF BURIAL Oct 9, 1911

UNDERTAKER E A Phillips ADDRESS Golden City

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 DadeTownship Grant

or

Village

or

City

REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 238File No. 34137

Primary Registration District No. _____ Registered No. _____

(NO. _____ St. _____ Ward _____)

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

FULL NAME

Elizabeth Koelliker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____ SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF DEATH _____, 191____
(Month) _____ (Day) _____ (Year)DATE OF BIRTH _____, 1____
(Month) _____ (Day) _____ (Year)I HEREBY CERTIFY, that I attended deceased from
_____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,AGE _____ yrs. _____ mos. _____ ds. If LESS than
1 day, _____ hrs. _____ min.and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:OCCUPATION
(a) Trade, profession, or
particular kind of work _____
(b) General nature of industry,
business, or establishment in
which employed (or employer) _____Fracture of femur
from accidental falling. XBIRTHPLACE
(City or town, State or foreign country)

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

NAME OF FATHER

Contributory
(SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.BIRTHPLACE OF FATHER
(City or town, State or foreign country)(Signed) B. Wilson M. D.

MAIDEN NAME OF MOTHER

_____, 191____ (Address) Golden CityBIRTHPLACE OF MOTHER
(City or town, State or foreign country)*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)

(Informant) _____

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) _____

Where was disease contracted
If not at place of death? _____

Filed _____, 191____

Former or usual residence _____

REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.

B. F. Wilson, Golden City

Revised United States Standard Certificate of Death

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

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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.)