

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.

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

PLACE OF DEATH
County Howell
Township Howell
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 384 File No. 34514
Primary Registration District No. 5235 Registered No. 143

FULL NAME Anna F. Meyer

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White MARRIAGE Married
(Write the word)

DATE OF BIRTH Sept 9 1872
(Month) (Day) (Year)

AGE 39 yrs. 29 mos. 29 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Macou Mo

PARENTS
NAME OF FATHER Wm Sattman
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Dora Truffall
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Meyer
(ADDRESS) West Plains Mo

Filed 10-9-1911 D. J. Nichols
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from April 22, 1911, to Oct 8, 1911, that I last saw her alive on Sept 4, 1911, and that death occurred, on the date stated above, at 12 - m.

The CAUSE OF DEATH* was as follows:
Pulmonary phthisis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) none
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Nichols M.D. M. D.
Oct 9 1911 (Address) West Plains 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 Macou Mo DATE OF BURIAL Oct 11 1911

UNDERTAKER McFarland and Co ADDRESS West Plains

By O. W. Leitch, D.P.

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*, *peritonaeum*, 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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Dunk Registration District No. 384 File No. _____
 Township Dunk or Village _____ Primary Registration District No. 5535 Registered No. 142
 City _____ (NO. _____ St. _____ Ward _____) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Anna F. Meyer

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE W. SINGLE M. MARRIED M. WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Sept 9 1872
 (Month) (Day) (Year)

AGE 24 yrs. 2 mos. 24 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)

BIRTHPLACE Warr. (City or town, State or foreign country)

PARENTS
 NAME OF FATHER Mr. Nathan
 BIRTHPLACE OF FATHER Prussia
 (City or town, State or foreign country)
 MAIDEN NAME OF MOTHER W. J. J. J. J.
 BIRTHPLACE OF MOTHER Germany
 (City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Sept 22, 1911, to Oct 8, 1911, that I last saw her alive on Sept 4, 1911, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Pulmonary Phthisis

(Duration) 11 yrs. 0 mos. 0 ds.

Contributory none
 (SECONDARY) (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Nichols & Elliott M. D.
Oct 9 1911 (Address) St. Louis, Mo.

*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
 (Informant) J. F. Meyer
 (ADDRESS) 11-9-11

Filed 11-9-11 1911 J. D. Nichols REGISTRAR
By O. P. Kuntz

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Warr. Mo. DATE OF BURIAL Oct 11 1911
 UNDERTAKER Wm. J. J. J. ADDRESS St. Louis, Mo.

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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