

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

PLACE OF DEATH York

County York  
Township Grant City  
or  
Village Grant City  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 963 File No. 36837  
Primary Registration District No. 4545 Registered No. 9

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

FULL NAME August Severs

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>June 15, 1891</u> <small>(Month) (Day) (Year)</small>		
AGE <u>20 yrs. 2 mos. 18 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Student, 8 1/2 yrs. School</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Mo</u>		
PARENTS	NAME OF FATHER <u>Audrey Severs</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Prussia</u>	
	MAIDEN NAME OF MOTHER <u>Rosa Severs</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Prussia</u>	

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Sept 3, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1911 to \_\_\_\_\_, 1911, that I last saw him alive on \_\_\_\_\_, 1911, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:  
Paralyzed for last 3 or 4 yrs. best of my information  
(Duration) (yrs.) (mos.) (ds.)

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) (yrs.) (mos.) (ds.)

(Signed) no Physician M. D.  
(Address) \_\_\_\_\_, 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Audrey Severs  
(ADDRESS) Grant City Mo

PLACE OF BURIAL OR REMOVAL Grant City Cemetery DATE OF BURIAL Sept 4, 1911  
UNDERTAKER Or Prugh ADDRESS Grant City

Filed Oct 10, 1911 John A. Severs REGISTRAR

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, 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.)



County Worth Registration District No. 903 File No. 96837  
 or  
 Township Grant City Primary Registration District No. 4545 Registered No. 9  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

FULL NAME

August Sievers

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Sept. 3, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1911 to \_\_\_\_\_, 1911,

DATE OF BIRTH June 15, 1891  
(Month) (Day) (Year)

that I last saw him alive on physician, 1911,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

AGE 20 yrs. 2 mos. 18 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Student

Paralyzed for last 3 or 4 years  
invalid and crippled  
best of informed

(b) General nature of industry, business, or establishment in which employed (or employer) School

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

NAME OF FATHER Andy Sievers

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

MAIDEN NAME OF MOTHER Rosa Dunk

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andy Sievers  
(ADDRESS) Grant City Mo.

Filed Oct 10, 1911 John Andrews  
REGISTRAR

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) No Physician M. D.  
\_\_\_\_\_ 1911 (Address)

\*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 Grant City Cemetery DATE OF BURIAL Sept 4, 1911

UNDERTAKER Orv Prust ADDRESS Grant City

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