

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important

PLACE OF DEATH

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

County Garrison
Township Rosk
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 303 File No. 27584
Primary Registration District No. 5420 Registered No. 39

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

FULL NAME Robert Frank Mueller

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Sept 18, 1890</u> (Month) (Day) (Year)		
AGE <u>21</u> yrs. <u>1</u> mos. <u>27</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Nov 15, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 14, 1911, to Nov 15, 1911, that I last saw him alive on Nov 14, 1911, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:
Fracture of Cranium
(accidental)
1911
(Duration) ___ yrs. ___ mos. 1 ds.

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

(Signed) W. P. Harman M. D.
Nov 15, 1911 (Address) Herrmann 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 <u>Little Berger Cat Cemetery</u>	DATE OF BURIAL <u>Nov 17, 1911</u>
UNDERTAKER <u>Edw. E. Ruediger</u>	ADDRESS <u>Herrmann Mo.</u>

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

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

PARENTS	NAME OF FATHER <u>John Mueller</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Little Berger Mo.</u>
	MAIDEN NAME OF MOTHER <u>Mary Jordan</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Herrmann Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Mueller
(ADDRESS) Herrmann Mo.

Filed Nov 15, 1911 Paul J. Hoffman
REGISTRAR

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.)



PLACE OF DEATH

REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.County BarrenTownship Road

Village _____

City _____ (NO. _____)

Registration District No. 303Primary Registration District No. 5420File No. 37584

Registered No. _____

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

FULL NAME

R. F. Miller

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)DATE OF BIRTH _____
(Month) (Day) (Year)AGE _____
IF LESS than
1 day, _____ hrs.
or _____ min.
_____ yrs. _____ mos. _____ ds.

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)

PARENTS

NAME OF
FATHERBIRTHPLACE
OF FATHER
(City or town, State or foreign country)MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-15
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

_____, 191_____, to _____, 191_____,
that I last saw him _____ alive on _____, 191_____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Blow on head
from falling tree
fracture cranium
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____

(SECONDARY)

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

(Signed) W. P. Harrison M. D.
H/16, 19124 (Address) Bellflower 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

DATE OF BURIAL

191_____

UNDERTAKER

ADDRESS

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