

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 Jackson
 Township Bless
 or
 Village _____
 or
 City _____ (NO. 3-1/2 mile N. on Indep. St.) Ward _____

Registration District No. 398 File No. 378-0

Primary Registration District No. 5054 Registered No. 222

FULL NAME Minnie Holtman

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Dec 25, 1836</u> <small>(Month) (Day) (Year)</small>		
AGE <u>75</u> yrs. — mos. — ds.		if LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Oct 31, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Daw. Hill, Mo., to 10-25, 1911, that I last saw her alive on 10-22, 1911, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Cariae failure
77
Don't know
(Duration) yrs. mos. ds.

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

Contributory —
(SECONDARY) (Duration) yrs. mos. ds.

BIRTHPLACE
 (City or town, State or foreign country) Germany

PARENTS	NAME OF FATHER <u>Joseph Diarcoff</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>
	MAIDEN NAME OF MOTHER <u>Don't know</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>

(Signed) H. J. Wood M. D.
10/31, 1911 (Address) Indep. 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) C. D. Schroeder
 (ADDRESS) Jackson County

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 _____

Filed Nov 1, 1911 C. E. Krumminger REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Independence Mo.</u>	DATE OF BURIAL <u>Nov 2, 1911</u>
UNDERTAKER <u>H. J. Wood Co.</u>	ADDRESS <u>Independence Mo.</u>

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 Jackson

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHTownship or Village or City BlueRegistration District No. 398

File No. _____

Primary Registration District No. 5554Registered No. 222

(NO. _____ St. _____ Ward _____)

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

FULL NAME Minnie Holtzman

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)DATE OF BIRTH 10/25, 1886
(Month) (Day) (Year)AGE 75 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ 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 (City or town, State or foreign country) GermanyNAME OF FATHER Jos. D. SchreffBIRTHPLACE OF FATHER (City or town, State or foreign country) PrussiaMAIDEN NAME OF MOTHER SchumannBIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. D. Schroeder(ADDRESS) Jackson W.FILED Feb. 1 1912 H. E. Kimminger REGISTRAROriginal file, date NOV 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10/31, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from _____, 191____, to 10/25, 1911, that I last saw her alive on 10/27, 1911, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Mitral stenosisDon't know
(Duration) _____ yrs. _____ mos. _____ ds.Contributory Thrombocytosis
(Secondary) Don't know
(Duration) _____ mos. _____ ds.(Signed) W. D. ... M. D.2-1, 1912 (Address) Independence

*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 Independence Mo. DATE OF BURIAL 11-2, 1911UNDERTAKER W. D. ... ADDRESS Independence

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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