

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 St. Charles
Township Postage Des Sires
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 752 File No. 42472

Primary Registration District No. 5597 Registered No. 22

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

FULL NAME Frederick Mathias

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF DEATH Dec 7th, 1911
(Month) (Day) (Year)

DATE OF BIRTH March 26, 1863
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 7:00 30, 1911, to Dec 7, 1911, that I last saw him alive on Dec 7, 1911, and that death occurred, on the date stated above, at 5:50 P. M.

AGE 48 yrs. 11 mos. 11 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 Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 102

Peritonitis
120 B 10
129 (Duration) _____ yrs. _____ mos. 8 ds.

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

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

NAME OF FATHER John Mathias

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

MAIDEN NAME OF MOTHER Janet Hoover

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

(Signed) Frank Sandlos (M. D.)
Dec 8, 1911 (Address) Postage Des Sires

*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) W. J. Mathias
(ADDRESS) St. Louis Mo

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 Dec 8, 1911, Frank Sandlos REGISTRAR

PLACE OF BURIAL OR REMOVAL County Cemetery St. Charles DATE OF BURIAL Dec 9th, 1911
UNDERTAKER H. Hallmeyer ADDRESS St. Charles Mo

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 septichaemia," "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.)

HUGH STEPHENS, JEFFERSON CITY.



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PLACE OF DEATH

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 DEATH

County *St. Charles*Township *Postage des Sioux*

Village

City

Registration District No. *756*

File No.

Primary Registration District No. *5997*Registered No. *22*

St. _____ Ward _____

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

FULL NAME *Frederick Mathias*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *male* COLOR OR RACE *white* SINGLE MARRIED *married*
WIDOWED OR DIVORCED
(Write the word)DATE OF BIRTH *March 26, 1863*
(Month) (Day) (Year)AGE *48* yrs. *11* mos. *11* ds. If LESS than
1 day, ___ hrs. or ___ min.OCCUPATION
(a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE
(City or town, State or foreign country) *Indiana*PARENTS
NAME OF FATHER *John Mathias*
BIRTHPLACE OF FATHER
(City or town, State or foreign country) *Switzerland*
MAIDEN NAME OF MOTHER *Don't know*
BIRTHPLACE OF MOTHER
(City or town, State or foreign country) *Switzerland*THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *C. A. Mathias*
(ADDRESS) *St. Louis Mo.*Filed *Feb 7* 191*2* *Frank Suedes*
REGISTRARDATE OF DEATH *Dec. 7, 1911*
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from *Nov. 30, 1911*, to *Dec. 7, 1911*,
that I last saw him alive on *Dec. 7, 1911*,
and that death occurred, on the date stated above, at *6:50 p.m.*The CAUSE OF DEATH* was as follows:
Peritonitis following Entertis
(Duration) ___ yrs. ___ mos. *8* ds.Contributory
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) *Frank Suedes M.D.*
Dec. 8, 1911 (Address) *Postage des Sioux*

*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 *City Cem., St. Charles* DATE OF BURIAL *Dec. 9, 1911*UNDERTAKER *H. C. W. Dalmeyer* ADDRESS *St. Charles, Mo.*Original file, date *Feb 8, 1912* All information called for must be written on this Supplemental Certificate

Revised United States Standard Certificate of Death

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

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42472

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