

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

PLACE OF DEATH

County Franklin  
Township St. Johns  
or  
Village  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 297 File No. 821  
Primary Registration District No. 5444 Registered No. 5

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

FULL NAME Angelina Klekamp

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widow  
(Write the word)

DATE OF BIRTH Feb 2, 1820  
(Month) (Day) (Year)

AGE 91 yrs. 11 mos. 10 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work ✓  
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

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

PARENTS  
NAME OF FATHER Key Klekamp  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
MAIDEN NAME OF MOTHER unknown  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Jules Keyes  
(ADDRESS) Washington Mo.

Filed Jan 15, 1912, O. L. Mueschke  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Died without medical, 1912  
(Month) Jan (Day) 14

I SOLEMNLY CERTIFY, that I attended deceased from Illness, 1912, to \_\_\_\_\_, 1912,  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 1912,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* was as follows:  
Senile debility.

Died without medical attention  
15 1/2  
(Duration) \_\_\_\_\_ yrs. 14 mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) 15  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) \_\_\_\_\_ M. D.  
(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 Beth. Cemetery DATE OF BURIAL 1/16, 1912  
UNDERTAKER Bleckmann & Co ADDRESS Washington 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*, *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*, *peritonæum*, 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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Franklin  
Township or Village or City St. Johns

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

Registration District No. 297  
Primary Registration District No. 5414

File No. 821  
Registered No. 5

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

FULL NAME Angelina Klekamp

PERSONAL AND STATISTICAL PARTICULARS

SEX f. COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED wd.  
(Write the word)

DATE OF BIRTH Feb 2 1870  
(Month) (Day) (Year)

AGE 91 yrs. 11 mos. 11 ds.  
If LESS than 1 day, hrs. or min.?

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) Germany

PARENTS  
NAME OF FATHER H. Klekamp  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
MAIDEN NAME OF MOTHER unknown  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) John Meyer  
(ADDRESS) Washington Mo.

Filed Jan 15 1912  
REGISTRAR O. S. Munch

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 14 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from death without, 1912, that I last saw her alive on medical attention and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH\* was as follows:  
senile debility  
(Duration) yrs. mos. ds.

Contributory (SECONDARY)  
(Duration) yrs. mos. ds.  
(Signs) O. S. Munch, Health Officer  
Jan 15 1912 (Address) Washington 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 Cath. Cem DATE OF BURIAL 1-16 1912

UNDERTAKER Bleckmann Co ADDRESS Washington Mo.

JAN \* All information called for must be written on this Supplementary Certificate.

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