

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 in very important.

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

PLACE OF DEATH
County St. Louis
Township Central
or
Village Delmar
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 790 File No. 2701
Primary Registration District No. 6033 Registered No. 15

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

FULL NAME Katherine M. Kepper

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 9, 1881
(Month) (Day) (Year)

AGE 30 yrs. 10 mos. 29 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Accountant
(b) General nature of industry, business, or establishment in which employed (or employer) 9-0

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

PARENTS
NAME OF FATHER Peter Grob
BIRTHPLACE OF FATHER (City or town, State or foreign country) Wis. with Mo.
MAIDEN NAME OF MOTHER Mull
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Minnesota

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. Kepper

(ADDRESS) Clayton R. D. #2

Filed 1/18 1915 W. Kepper
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 10, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January, 1908, to Nov, 1911, that I last saw her alive on Nov 8, 1911,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
23A

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Pharyngeal Tuberculosis
(SECONDARY)
(Duration) ___ yrs. 6 mos. ___ ds.
(Signed) Royd Moore M. D.
Jan 12, 1915 (Address) Delmar

*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 Emmanuel's Cemetery DATE OF BURIAL Jan 12, 1915
UNDERTAKER P. J. Barron ADDRESS Delmar

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

County

St Louis
Central

Township

or

Village

or

City

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

Registration District No.

790

Primary Registration District No.

6033a

File No.

2701
15

Registered No.

FULL NAME

Katherine M Kepper

[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 female COLOR OR RACE white SINGLE MARRIED Married
WIDOWED OR DIVORCED (If ritz the word)

DATE OF DEATH

June 10, 1912
(Month) (Day) (Year)

DATE OF BIRTH

March 9, 1881
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
June 10, 1912, to Nov 1, 1912,

AGE

30 yrs. 10 mos. 39 ds.

IF LESS than
1 day, hrs. or min.that I last saw her alive on Nov 8, 1912,
and that death occurred, on the date stated above, at 4 p.m.

OCCUPATION

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

Housewife

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

The CAUSE OF DEATH* was as follows:

Pulmonary
Tuberculosis

BIRTHPLACE

(City or town,
State or foreign country)

Groves, St Louis Co, Mo

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

Pharyngeal Tuberculosis
(Duration) yrs. 6 mos. ds.

PARENTS

NAME OF
FATHER

Pat O Herb

BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

Perrville, Mo

MAIDEN NAME
OF MOTHER

S M Wolf

BIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

Minnesota

(Signed) Roy D Moore M. D.
1/12 1912 (Address) Olivette*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)

K. Kepper
Clayton R. D. 2

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmanuals Cem.

Jan 13, 1912

UNDERTAKER

ADDRESS

U. L. Barrman

Creve Coeur
Mo

Original file, of

JAN

1912

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

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