

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 <u>Franklin</u>		Registration District No. <u>296</u>	File No. <u>4827</u>
Township <u>Union</u>		or		Primary Registration District No. <u>5413</u>	Registered No. _____
Village _____		or		City _____ (NO. _____) _____ St. _____ Ward _____	(If death occurred in a hospital or institution, give its NAME instead of street and number)
FULL NAME <u>Oliver Jacob M. Meisner</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>infant</u>	DATE OF DEATH <u>Feb 8</u> , 191 <u>2</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Dec 15</u> , 191 <u>1</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Jan 12</u> , 191 <u>2</u> to <u>Jan 22</u> , 191 <u>2</u> , that I last saw him alive on <u>Jan 22</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>5:45</u> a.m. The CAUSE OF DEATH* was as follows: <u>Marasmus</u>		
AGE <u>2</u> yrs. <u>7</u> mos. <u>0</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?			
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓ 0</u>			(Duration) ___ yrs. ___ mos. <u>12</u> ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Union Twp</u>			Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.		
PARENTS	NAME OF FATHER <u>John H. Meisner</u>		(Signed) <u>O. L. Munch</u> M. D. <u>Feb 9</u> , 191 <u>2</u> (Address) <u>Washington Mo</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Franklin Co Mo</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	MAIDEN NAME OF MOTHER <u>Katherine Hoelcher</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Franklin Co Mo</u>		At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>John H. Meisner</u>			Where was disease contracted if not at place of death?		
(ADDRESS) <u>Union Mo</u>			Former or usual residence _____		
Filed <u>Feb 9</u> , 191 <u>2</u> <u>Ed. DeLange</u>			PLACE OF BURIAL OR REMOVAL <u>Prokew. Cem</u>		DATE OF BURIAL <u>Feb 9</u> , 191 <u>2</u>
REGISTRAR			UNDERTAKER <u>Thy Horn</u>		ADDRESS <u>Prokew 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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
 County Franklin
 Township Union
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 296 File No. 4827
 Primary Registration District No. 5713 Registered No. _____

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

FULL NAME Aloys Jacob M. Meisner

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) S

DATE OF BIRTH Dec 15, 1911
 (Month) (Day) (Year)

AGE 2 yrs. 2 mos. 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)

Infant Marasmus

BIRTHPLACE
 (City or town, State or foreign country)

Union Mo

PARENTS
 NAME OF FATHER John H Meisner
 BIRTHPLACE OF FATHER Franklin Co Mo
 (City or town, State or foreign country)
 MAIDEN NAME OF MOTHER Catherine Horbich
 BIRTHPLACE OF MOTHER Franklin Co Mo
 (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H Meisner
 (ADDRESS) Union Mo

Filed July 9 1912 by Ed Harrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 8, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 12, 1912, to Jan 22, 1912, that I last saw him alive on Jan 22, 1912, and that death occurred, on the date stated above, at 5-45 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus
Inherited constitutional weakness and poor surroundings
 (Duration) ___ yrs. ___ mos. 12 ds.

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

(Signed) O. L. Munch M. D.
Apr 10, 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 Prakow Cem DATE OF BURIAL Feb 9, 1912

UNDERTAKER Hy Horn ADDRESS Prakow Mo

Original file, date FEB, 1912 All information called for must be written on this Supplementary Certificate.

RECORD WITH UNCHANGING LINK - THIS IS A PERMANENT RECORD

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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.)