

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.

PLACE OF DEATH  
County Essex  
Township Richland  
or  
Village  
or  
City (NO. St. Ward)

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH  
Registration District No. 1134 File No. 1 13115  
Primary Registration District No. 5421-9 Registered No. 1

FULL NAME Marria Barbara Braun

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

## PERSONAL AND STATISTICAL PARTICULARS

SEX ☒ MALE ☒ FEMALE ☒ COLOR OR RACE ☒ WHITE ☒ OTHER SINGLE ☒ MARRIED ☒ WIDOWED ☒ OR DIVORCED (Write the word)

DATE OF BIRTH Apr 19 1840  
(Month) (Day) (Year)

AGE 71 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS  
NAME OF FATHER John Storch  
BIRTHPLACE OF FATHER (City or town, State or foreign country)  
MAIDEN NAME OF MOTHER  
BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gert Braun

(ADDRESS)

Filed Apr 7 1912 Howard H. Homan  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 5 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4/5 7:16 a.m., 1912, to 4/5 8:40 a.m., 1912, that I last saw her alive on 4/5, 1912, and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH\* was as follows:

Apoplexy  
64  
(Duration) 64 yrs. 6 mos. 16 ds.

Contributory  
(SECONDARY)  
(Duration) 64 yrs. 6 mos. 16 ds.

(Signed) Howard H. Homan M. D.  
Apr 5 1912 (Address) Poppenhausen Germany

\*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 64 yrs. 6 mos. 16 ds. In the State 64 yrs. 6 mos. 16 ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL St Marys RC Cemetery DATE OF BURIAL Apr 8 1912

UNDERTAKER Christ F. P. P. ADDRESS Poppenhausen Germany

# 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 Gasconade  
 Township Richland  
 or  
 Village  
 or  
 City

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

Registration District No. 1134 File No. 13115  
 Primary Registration District No. 5421-A Registered No. 1  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Maria Barbara Braun

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Sept. 19, 1840  
 (Month) (Day) (Year)

AGE 71 yrs. 7 mos. 16 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ 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) Bapenhansen Ger.

PARENTS NAME OF FATHER John Storck  
 BIRTHPLACE OF FATHER Germany  
 MAIDEN NAME OF MOTHER Elizabeth  
 BIRTHPLACE OF MOTHER Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ferdinand Braun  
 (ADDRESS) Potsdam mo

Filed 4/3/12 1912 Howard Workman & X  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 5, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4:55 A.M., 1912, to 4:55-8:40 P.M. 1912, that I last saw her alive on 4:5, 1912, and that death occurred, on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH\* was as follows:

Apoplexy

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Howard Workman M. D. Apr. 5, 1912 (Address) Potsdam 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 St Mary's R.C. Cem. Miss. Mo DATE OF BURIAL 4/8, 1912

UNDERTAKER Christ F. Pope ADDRESS Morrison mo

# Revised United States Standard Certificate of Death

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

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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.)