

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

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 Laurie
Township _____
or
Village _____
or
City Mt Vernon Mo (NO. _____) St. _____ Ward _____

Registration District No. 470 File No. 14062
Primary Registration District No. 4258 Registered No. 18

FULL NAME John Bernhard Smith

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH November 5, 1862
(Month) (Day) (Year)

AGE 49 yrs. 5 mos. 14 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Grocer & Hardware

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

PARENTS
NAME OF FATHER Peter Smith
BIRTHPLACE OF FATHER Oberlahr, Prussia
MAIDEN NAME OF MOTHER Mary Katharina Blaesmer
BIRTHPLACE OF MOTHER St. Louis Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred A Smith

(ADDRESS) Webster Groves Mo

Filed Apr 22 1912 F R. Knapp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 18, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 18, 1912, to _____, 1912, that I last saw him alive on Apr 18, 1912, and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:

Heart paralyzed
(Duration) about 30 min. ds.

Contributory scot / known
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. C. Koehery M. D.
Apr 22 1912 (Address) Mt Vernon

*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 S. O. O. H. Co DATE OF BURIAL Apr 22 1912

UNDERTAKER Geo. B. Orr ADDRESS Mt Vernon

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, peritonaeum*, 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**

X

PLACE OF DEATH Lawrence
 County Lawrence Registration District No. 470 File No. 14062
 Township _____ or Village _____ Primary Registration District No. 4283 Registered No. 13
 City Mt Vernon Mo. (NO. _____) St. _____ Ward _____
 FULL NAME John Berichard Smith (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 <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>m</u>
DATE OF BIRTH <u>Nov. 5</u> , 1862 (Month) (Day) (Year)		
AGE <u>49 yrs. 5 mos. 14 ds.</u>		IF LESS than 1 day, ___ hrs or ___ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>merchant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Grocery Station</u>		
BIRTHPLACE (City or town, State or foreign country) <u>St Louis Mo.</u>		
PARENTS	NAME OF FATHER <u>Peter Smith</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Prussia</u>	
	MAIDEN NAME OF MOTHER <u>Marie Katherine Krosney</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>St Louis Mo.</u>	

DATE OF DEATH April 18, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 18, 1912, to April 18, 1912, that I last saw him alive on April 18, 1912, and that death occurred, on the date stated above, at 8:52 a.m.

The CAUSE OF DEATH* was as follows:
Heart paralysis

(Duration) abt 30 min ds.

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

(Signed) _____ M. D. X
 _____ 1912 (Address) _____ X

*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) Fred A. Smith
 (ADDRESS) Walter Gross Mo.

FILED April 22 1912 G. L. Knapp
 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>S. O. F. Cem.</u>	DATE OF BURIAL <u>Apr 22 1912</u>
UNDERTAKER <u>Geo. B. Venz</u>	ADDRESS <u>Mt Vernon</u>

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N. P.

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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.)