

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.

V

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

PLACE OF DEATH
County Oregon

Township Piney or
Village _____ or
City _____

Registration District No. 630 File No. 14405

Primary Registration District No. 5844 Registered No. 10

City _____ No. _____ St. _____ Ward _____

FULL NAME Thomas McLane

(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>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	DATE OF DEATH <u>March 17, 1912</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Sept 28, 1878</u> (Month) (Day) (Year)			HEREBY CERTIFY that I attended deceased from <u>March 1, 1912</u> to <u>March 17, 1912</u> , that I last saw her alive on <u>March 17, 1912</u> , and that death occurred, on the date stated above, at <u>8:00</u> a. m.	
AGE <u>33</u> yrs. <u>5</u> mos. <u>19</u> ds.		if LESS than 1 day, ____ hrs. or ____ min.?	CAUSE OF DEATH* was as follows: <u>Cerebral Abscess</u> <u>12-18-11</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u>		(b) General nature of industry, business, or establishment in which employed (or employer) <u>9-0</u>	Contributory <u>Cholecystitis</u> mos. <u>07</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Konigsberg Germany</u>		NAME OF FATHER <u>William Rommel</u>		
PARENTS	NAME OF FATHER <u>William Rommel</u>		BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Konigsberg Germany</u>	
	MAIDEN NAME OF MOTHER <u>Dora Schroeder</u>		BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Konigsberg Germany</u>	
	THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>T. McLane</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	(ADDRESS) <u>Alton, Mo.</u>		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 _____	
Filed <u>4/18</u> 191 <u>2</u>	REGISTRAR <u>T. H. Piles</u>		PLACE OF BURIAL OR REMOVAL <u>Smith Cemetery</u>	DATE OF BURIAL <u>March 18, 1912</u>
			UNDERTAKER <u>Neighbors</u>	ADDRESS <u>Alton, 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*, *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.)



WRITE PLAINLY. WITH ENCODING INK— IS A PERMANENT RECORD.

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

X

PLACE OF DEATH

County Oregon
Township Piney
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

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

Registration District No. 636 File No. _____
Primary Registration District No. 5844 Registered No. 10

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

FULL NAME Johanna Mc Lain

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED m
(Write the word)

DATE OF DEATH Mar. 17, 1912
(Month) (Day) (Year)

DATE OF BIRTH Sept. 28, 1878
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 1, 1912, to Mar 17, 1912, that I last saw h. e. alive on Mar 17, 1912, and that death occurred, on the date stated above, at 8 P. m.

AGE 33 yrs. 5 mos. 19 ds.
IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:
Cerebral abscess
Cholicystitis
(Duration) _____ yrs. _____ mos. 17 ds.

OCCUPATION (a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Contributory Cholicystitis
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. L. Ober M. D.
6/10, 1912 (Address) Altou Mrs

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

PARENTS
NAME OF FATHER William Brown
BIRTHPLACE OF FATHER (City or town, State or foreign country) Konigsberg Germany
MAIDEN NAME OF MOTHER Dora Schroeder
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Konigsberg Germany

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Mc Lain
(ADDRESS) Altou Mrs.

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 _____

FILED 4/10, 1912
REGISTRAR J. L. Ober

PLACE OF BURIAL OR REMOVAL Swiss Cemetery DATE OF BURIAL Mar. 18, 1912
UNDERTAKER Neighbors ADDRESS Altou Mrs

APR 4 18

Revised United States Standard Certificate of Death

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

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