

WHILE FURNISHING 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 429

PLACE OF DEATH
County Buchanan

Township _____

or Village _____

or City St. Joseph

Registration District No. 85

Primary Registration District No. 1001

(NO. Sisters Hospital)

File No. 16275

Registered No. 429

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

FULL NAME Carrie Silwander

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Single

DATE OF BIRTH Sept. 9, 1864
(Month) (Day) (Year)

AGE 47 yrs. 7 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) g-310

BIRTHPLACE (City or town, State or foreign country) Sweden

NAME OF FATHER Unknown

BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden

MAIDEN NAME OF MOTHER Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence Hansen

(ADDRESS) 101 So 9 St. St. Joseph Mo.

Filed May 11, 1912 A. B. Kelling REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 11, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 28, 1912 to May 10, 1912, that I last saw her alive on March 10, 1912, and that death occurred, on the date stated above, at 6:45 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage and Paralysis 81A 82A
(Duration) 10 yrs. 0 mos. 12 ds.

Contributory none
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) M. B. Gray M. D. May 11, 1912 (Address) St. Joseph 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 0 yrs. 1 mos. 12 ds. In the unknown State 0 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death? St. Joseph Mo.

Former or usual residence St. Joseph Mo.

PLACE OF BURIAL OR REMOVAL Gilford Mo. DATE OF BURIAL May 12, 1912

UNDERTAKEER R. Meierhoffer ADDRESS 824 Federal

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) *Colton 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*, *Sarcoma*, 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 "Asthemia," "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.)

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

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Buchanan

Township _____

Registration District No. 85

File No. _____

or Village _____

Primary Registration District No. 1001

Registered No. 429

or City St. Joseph

(NO. Sisters Hosp.)

St. _____ Ward _____

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

FULL NAME Carrie Silvaner

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH May 11, 1912
(Month) (Day) (Year)

DATE OF BIRTH Sept. 9, 1864
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 28, 1912, to May 10, 1912, that I last saw her alive on Mar. 10, 1912, and that death occurred, on the date stated above, at 6:25 a.m.

AGE 47 yrs. 7 mos. 2 ds.
If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage & paralytic Bulbar Paralysis
(Duration) yrs. 1 mos. 12 ds.

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

Contributory none
(SECONDARY) (Duration) yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) Sweden

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) Sweden
MAIDEN NAME OF MOTHER Wm.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wm.

(Signed) M.D. Gray M. D.
July 22, 1912 (Address) St Joseph Mo
*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) Florence Hansen
(ADDRESS) 1015 9th St. St Joseph.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. 1 mos. 12 ds. in the State yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? St Joseph Mo.
Former or usual residence " " "

Filed July 22, 1912 by MBS Kelling REGISTRAR

PLACE OF BURIAL OR REMOVAL Gilford Mo. DATE OF BURIAL May 12, 1912
UNDERTAKER R. Meierhoffer ADDRESS 824 Felix

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.)