

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	Scott		Registration District No.	816	File No.
Township	Kelso		Primary Registration District No.	6068	Registered No.
Village					
City			(NO. _____) (St. _____) (Ward _____)		
FULL NAME			Walter Lewis Albrecht		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
Male	White	Single	June 18, 1912		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
February 28, 1912			May 12, 1912, to June 18, 1912		
AGE			that I last saw him alive on June 18, 1912		
3 yrs. 20 mos. 10 ds.			and that death occurred, on the date stated above, at 4 p.m.		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work			Marasmus - Tuberculosis		
(b) General nature of industry, business, or establishment in which employed (or employer)			23A		
BIRTHPLACE			158		
(City or town, State or foreign country)			(Duration) x yrs. 1 mos. 17 ds.		
NAME OF FATHER			Contributory (SECONDARY) x		
John William Albrecht			(Signed) L. S. Mayfield M. D.		
BIRTHPLACE OF FATHER			June 18, 1912 (Address) Leavenworth Mo		
Scott Co., Mo.			*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			LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
Pauline Francis Rohrer			At place of death yrs. mos. ds. In the State yrs. mos. ds.		
BIRTHPLACE OF MOTHER			Where was disease contracted if not at place of death?		
Scott Co., Mo.			Former or usual residence		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			PLACE OF BURIAL OR REMOVAL		
(Informant) John William Albrecht			Illino. Mo		
(ADDRESS) Leavenworth, Mo.			DATE OF BURIAL		
June 29, 1912			6/19/12		
Filed			UNDERTAKER		
G. M. Gange			R. Bismarck Foraker Mo		
REGISTRAR			ADDRESS		

# 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 septichaemia," "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.)

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should be stated EXACTLY. PHYSICIANS should state the full name of the deceased, the full name of the occupation is very important.

PLACE OF DEATH

County Scott  
 Township Kelso  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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. 816 File No. 21940  
 Primary Registration District No. 6065 Registered No. 74

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

FULL NAME Walton Lewis Albrecht

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE Single  
 MARRIED  
 WIDOWED  
 OR DIVORCED  
 (Write the word)

DATE OF BIRTH Feb. 28, 1912  
 (Month) (Day) (Year)

AGE 3 yrs. 20 mos. 20 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

BIRTHPLACE  
 (City or town, State or foreign country) Scott Co. Mo.

PARENTS  
 NAME OF FATHER John W. Albrecht  
 BIRTHPLACE OF FATHER Scott Co. Mo.  
 MAIDEN NAME OF MOTHER Pauline Francis Bohnhardt  
 BIRTHPLACE OF MOTHER Scott Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) John William Albrecht  
 (ADDRESS) Illmo., Mo.

Filed June 26, 1912 G. Sample REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from May 1, 1912, to June 18, 1912, that I last saw him alive on June 18, 1912, and that death occurred, on the date stated above, at 4p. m.

The CAUSE OF DEATH\* was as follows:  
Marasmus  
Pulmonary tuberculosis  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Z. B. Mayfield M. D.  
June 18, 1912 (Address) Illmo., Mo.

State the Disease Causing Death, or, in deaths from Violent Causes, state the 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 Illmo., Mo. DATE OF BURIAL 6-19, 1912  
 UNDERTAKER P. Bussendeir ADDRESS Fornfelt, Mo.

N. B.—CAUSE OF DEATH

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