

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.

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

PLACE OF DEATH Cass
County Cass
Township Polk
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 139 File No. 22470
Primary Registration District No. 5224 Registered No. 4

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

FULL NAME Rosa Margaret Epple

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>July 21, 1912</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Oct 3, 1870</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>7-13, 1912</u> , to <u>7-21, 1912</u> , that I last saw her alive on <u>7-20, 1912</u> , and that death occurred, on the date stated above, at <u>5.30 p.m.</u>		
AGE <u>41</u> yrs. <u>9</u> mos. <u>18</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Parovarian cyst</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>None</u>			<u>191A</u> (Duration) ___ yrs. ___ mos. <u>8</u> ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>			Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.		
PARENTS	NAME OF FATHER <u>Geswin</u>		(Signed) <u>M. Beckman</u> M. D.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>		<u>7-21, 1912</u> (Address) <u>Strasbourg</u>		
	MAIDEN NAME OF MOTHER <u>Unknown</u>		*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Henry Epple</u>			Where was disease contracted if not at place of death? _____		
(ADDRESS) <u>Strasbourg Mo</u>			Former or usual residence _____		
Filed <u>7-21, 1912</u>			PLACE OF BURIAL OR REMOVAL <u>Bluff Spgs. Cem.</u>		DATE OF BURIAL <u>7-22, 1912</u>
REGISTRAR <u>M. Beckman</u>			UNDERTAKER <u>Parker & How</u>		ADDRESS <u>Pleasant Hill, 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.)



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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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



PLACE OF DEATH
 County Cass
 Township Polk
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 159 File No. 22470
 Primary Registration District No. 5224 Registered No. 4

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

FULL NAME Rosa Margaret Epple

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX female COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH Oct. 3, 1870
 (Month) (Day) (Year)
 AGE 41 yrs. 9 mos. 18 ds. IF LESS than 1 day, hrs. or mins.

DATE OF DEATH July 21, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from July 13, 1912, to July 21, 1912
 that I last saw her alive on July 20, 1912
 and that death occurred, on the date stated above, at 5:30 a.m.

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

The CAUSE OF DEATH* was as follows:
Parovarian cyst
 (Duration) _____ yrs. _____ mos. 8 ds.

BIRTHPLACE (City or town, State or foreign country) Germany
 NAME OF FATHER H. Epple
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
 MAIDEN NAME OF MOTHER Unknown
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. Beckman M. D.
7-21, 1912 (Address) Strasburg
 *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) Henry Epple
 (ADDRESS) Strasburg Mo.

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 7-21 1912 W. Beckman REGISTRAR

PLACE OF BURIAL OR REMOVAL Bluff Spgs. Cem. DATE OF BURIAL 7-22, 1912
 UNDERTAKER Parker & Hon. ADDRESS Hesperant Hill

Revised United States Standard Certificate of Death

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