

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

County St. Francois

Township _____

Village _____

City Flat River Mo. (NO. _____ St.; _____ Ward)

Registration District No. 774

File No. 24035 24135

Primary Registration District No. 4465

Registered No. _____

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

FULL NAME

Michael Ewanschook

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Single</u>	DATE OF DEATH <u>July 3, 1912</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>November 18, 1911</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>July 3, 1912</u> , to <u>July 3, 1912</u> , that I last saw him alive on <u>July 3, 1912</u> , and that death occurred, on the date stated above, at <u>7 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Cholera Infantum</u> <u>119A</u>	
AGE <u>X</u> yrs. <u>7</u> mos. <u>16</u> ds.	IF LESS than 1 day, <u>X</u> hrs. or <u>X</u> min.?		(Duration) _____ yrs. _____ mos. _____ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>St. Louis Mo</u>			(Signed) <u>Edw. C. Rohrbach</u> M. D. <u>July 4, 1912</u> (Address) <u>Flat River Mo</u>	
PARENTS	NAME OF FATHER <u>John Ewanschook</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Austria</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER <u>Faurina Klopka</u>		Where was disease contracted If not at place of death? _____ Former or _____ usual residence.	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Austria</u>		THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Ewanschook</u> (ADDRESS) <u>Flat River Mo</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____		PLACE OF BURIAL OR REMOVAL <u>De Sloga County</u> DATE OF BURIAL <u>July 5, 1912</u>		
Filed <u>7/3</u> 1912		REGISTRAR <u>Henry Ruter</u> ADDRESS <u>Flat River Mo</u>		

USE OF DEATH IS DETERMINED BY THE STATE OF MIND AT THE TIME OF DEATH
AGREEMENT SHOULD BE MADE BY THE STATE OF MIND AT THE TIME OF DEATH
STATE OF MIND AT THE TIME OF DEATH

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*, *Composer*, *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*, *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 "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 periitonitis," 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.)



PLACE OF DEATH

County St. Francois

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

Township _____

Registration District No. 774

File No. 24035

or Village _____

Primary Registration District No. 4465

Registered No. _____

or City Flat River

(NO. _____ St.: _____ Ward)

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

FULL NAME

Michael Ewaneschook

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH July 3, 1912
(Month) (Day) (Year)

DATE OF BIRTH Nov. 18, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 3, 1912, to July 3, 1912
that I last saw him alive on July 3, 1912

AGE 7 yrs. 16 mos. 16 ds. If LESS than 1 day, _____ hrs. or _____ min.

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

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

Cholera Infantum

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

(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER John Ewaneschook

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) Edw. C. Rohrbock, D.
July 4, 1912 (Address) Flat River

MAIDEN NAME OF MOTHER Faustina Klopka

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

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

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

Where was disease contracted If not at place of death? _____

(Informant) John Evans Trebrekey
(ADDRESS) Flat River

Former or usual residence _____

Filed 7/6 1912 MA Goffney REGISTRAR

PLACE OF BURIAL OR REMOVAL De Sloge Cem. DATE OF BURIAL July 5, 1912

UNDERTAKER Henry Rinker ADDRESS Flat River

Original file date _____ 1912

All information called for must be written on this Supplementary Certificate

N. B.—Every form was prepared and printed at the Missouri State Board of Health, St. Louis, Mo. It is to be filled out by the Registrar, and it is to be returned to the Registrar, who will forward it to the State Board of Health, St. Louis, Mo. It is to be filled out by the Registrar, and it is to be returned to the Registrar, who will forward it to the State Board of Health, St. Louis, Mo.

SUPPLEMENTARY

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," "Hæmorrhage," "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.)