

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

PLACE OF DEATH

County Egg Creek

Township Frank

Village _____

City _____ (NO. _____)

Registration District No. 312

Primary Registration District No. 5420

File No. 25990

Registered No. 27

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

FULL NAME Jane E. Browns

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF BIRTH May 28, 1822
(Month) (Day) (Year)

AGE 90 yrs. 2 mos. 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 90

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

PARENTS
NAME OF FATHER Charles Kebr
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Jane E. Kebr
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Franklin Browns
(ADDRESS) Hermann Mo

Filed Aug 12, 1913. Emil Heppner
REGISTRAR

DATE OF DEATH Aug 12th, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 9th, 1912, to Aug 12, 1912, that I last saw her alive on Aug 9th, 1912, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:
Paralytic stroke

19 (Duration) yrs. 3 mos. 3 ds.

Contributory old age
(SECONDARY) (Duration) yrs. 3 mos. 3 ds.

(Signed) W. C. Wessel M. D.
Aug 12th, 1912 (Address) Hermann 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 ___ 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 Family Cemetery DATE OF BURIAL Aug 14, 1912

UNDERTAKER Edw. E. Ruediger ADDRESS Hermann Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, peritoneum*, 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 "Asihenia," "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.)

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

X

PLACE OF DEATH
County Gasconade
Township Road
or
Village
or
City

Registration District No. 303 File No. 25990
Primary Registration District No. 5420 Registered No. 27
St.: _____ Ward)

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

FULL NAME Jane E. (Bruens) Powers

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug. 12, 1912
(Month) (Day) (Year)

DATE OF BIRTH May 28, 1822
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 9, 1912, to Aug. 12, 1912, that I last saw her alive on Aug. 9, 1912, and that death occurred, on the date stated above, at 1:30 a.m.

AGE 90 yrs 2 mos 10 ds. If LESS than 1 day, hrs or min

The CAUSE OF DEATH* was as follows:
Paralytic stroke

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

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

(Duration) yrs. mos. ds. 3

PARENTS NAME OF FATHER Charles Kehr

Contributory Old age
(SECONDARY) (Duration) yrs. mos. ds.

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

(Signed) M. C. Weigel M. D. Aug. 12, 1912 (Address) Hermann, Mo.

MAIDEN NAME OF MOTHER Jane E. Kehr

*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) Germany

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) Frank Bruens
(ADDRESS) Hermann, Mo.

Former or usual residence.

Filed Aug. 21, 1912 Emil L. Hoff REGISTRAR

PLACE OF BURIAL OR REMOVAL Family Cemetery DATE OF BURIAL Aug. 17, 1912
UNDERTAKER Edw. E. Pruediger ADDRESS Hermann, Mo.

This certificate may be properly classified. Exact statement of OCCUPATION is very important.

AUG

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.

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*, *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 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.)

Marital status, place of birth of deceased, mothers maiden name amended by affidavit of great granddaughter verified by History book, citizen roll of Germany 1-19-07

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

PLACE OF DEATH
 County Gasconade
 Township Frank or _____
 Village _____ or _____
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 312 File No. 25990
 Primary Registration District No. 5420 Registered No. 27

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

FULL NAME Jane E. Browns

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED DIVORCED Widowed
 (Write the word)

DATE OF BIRTH May 28, 1822
 (Month) (Day) (Year)

AGE 90 yrs. 2 mos. 15 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) 9-0

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

PARENTS
 NAME OF FATHER Charles Weber
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
 MAIDEN NAME OF MOTHER Anna Margarethe Christina Victoria Grae
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Franklin Browns
 (ADDRESS) Hermann Mo
 Filed Aug 12, 1912 Edw. E. Hoffmeister REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 12th, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 9th, 1912, to Aug 12, 1912, that I last saw her alive on Aug 9th, 1912, and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:
1st Paralytic stroke
1st (Duration) yrs. mos. 3 ds.

Contributory old age (SECONDARY) (Duration) yrs. mos. 8 ds.
 (Signed) W. E. Weppel M. D.
Aug 12th, 1912 (Address) Hermann 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 ___ 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 Family Cemetery DATE OF BURIAL Aug 14, 1912
 UNDERTAKER Edw. E. Reddicks ADDRESS Hermann Mo

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Gasconade

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

Township RoskRegistration District No. 303File No. 25990

Village _____

Primary Registration District No. 0420Registered No. 27

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Jane E. (Bruens) (Browner)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE Widowed MARRIED Single WIDOWED Single OR DIVORCED Single (Write the word)DATE OF BIRTH May 28, 1822
(Month) (Day) (Year)AGE 90 yrs. 2 mos. 10 ds. If LESS than 1 day, hrs. or min.OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE (City or town, State or foreign country) Eisenach, GermanyNAME OF FATHER Charles DehrBIRTHPLACE OF FATHER (City or town, State or foreign country) GermanyMOTHER'S NAME Anna Margarethe Christina Victoria Gracie
OF MOTHER Jane E. DehrBIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Bruens(ADDRESS) Hermann, Mo.Filed Aug 21, 1912 Paul L. Hoff REGISTRAR

AUG

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 12, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug. 9, 1912, to Aug. 12, 1912, that I last saw her alive on Aug. 9, 1912, and that death occurred, on the date stated above, at 1:30 a.m.The CAUSE OF DEATH* was as follows: Paralytic stroke(Duration) _____ yrs. _____ mos. 3 ds.Contributory Old age
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.(Signed) W. P. Stepp M. D. Hermann, Mo.
Aug. 12, 1912 (Address)

*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 _____ 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 Family Cemetery DATE OF BURIAL Aug. 14, 1912UNDERTAKER Edw. E. Pruediger ADDRESS Hermann, Mo.

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.