

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

PLACE OF DEATH

County Gasconade

Township Roubidoux

Village _____

City Hermann (NO. _____)

Registration District No. 303

Primary Registration District No. 5420

File No. 29277

Registered No. 32

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

FULL NAME Elsie Anthes

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF BIRTH Nov. 4, 1910
(Month) (Day) (Year)

AGE 1 yrs. 10 mos. ds. IF LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Sept 17th 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 19th, 1912, to Sept 19th, 1912, that I last saw her alive on Sept 19th, 1912, and that death occurred, on the date stated above, at 7:35 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis
16
(Duration) ___ yrs. ___ mos. 1 ds.

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

(Signed) W. C. Wessel M. D.
Sept. 19, 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 _____

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE (City or town, State or foreign country) First Creek Hermann Mo.

NAME OF FATHER Wm. Anthes

BIRTHPLACE OF FATHER (City or town, State or foreign country) Gasconade Mo.

MAIDEN NAME OF MOTHER Gillie Puschel

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Hermann Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Wm. D. Anthes

(ADDRESS) Hermann Mo.

Filed Sept. 20, 1912 Ernest Hoffer REGISTRAR

PLACE OF BURIAL OR REMOVAL Hermann Mo. DATE OF BURIAL Sept. 21, 1912

UNDERTAKER B. H. Hammit ADDRESS Hermann Mo.

COPY OF DEATH IN plain terms, so that it may be properly understood. Exact statement of OCCUPATION in every

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, 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 septicæmia," "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.)

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 Gasconade
Township Roark
or
Village
or
City

Registration District No. 303 File No. 29277
Primary Registration District No. 5420 Registered No. 32
St. _____ Ward _____

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

FULL NAME Elsie Anthes

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 DEATH Sept. 19, 1912
(Month) (Day) (Year)

DATE OF BIRTH Nov. 6, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 19, 1912, to Sept. 19, 1912 that I last saw her live on Sept. 19, 1912, and that death occurred, on the date stated above, at 7:35 p.m.

AGE 1 yrs. 10 mos. ds. IF LESS than 1 day, ___ hrs. or ___ min.

The CAUSE OF DEATH* was as follows:
Infantile paralysis
(Duration) 1 yrs. 1 mos. 2 ds.

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

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

NAME OF FATHER Wm. Anthes

BIRTHPLACE OF FATHER (City or town, State or foreign country) Gasconade Mo.

MAIDEN NAME OF MOTHER Jesse Poister

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Herusalem Mo.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. C. Kessel M. D. Sept. 19, 1912 (Address) Herusalem 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) Wm. G. Anthes (ADDRESS) Herusalem 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 Sept 19 1912 W. C. Kessel REGISTRAR

PLACE OF BURIAL OR REMOVAL Herusalem Mo. DATE OF BURIAL Sept. 2, 1912
UNDERTAKER R. H. Hamilton ADDRESS Herusalem Mo.

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.)