

MARGIN RESERVED FOR BINDING

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 Saline ✓  
 County Saline  
 Township Grand Pass Registration District No. 795 File No. 31566  
 or  
 Village \_\_\_\_\_ Primary Registration District No. 6038 Registered No. 24  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

FULL NAME William J. Lemmer (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Oct 2, 1834  
(Month) (Day) (Year)

AGE 77 yrs. 11 mos. 16 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) 11 p. 02

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

PARENTS

NAME OF FATHER	<u>Robert Lemmer</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country)	<u>Virginia</u>
MAIDEN NAME OF MOTHER	<u>Margaret Orbin</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<u>Virginia</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) W. H. Lemmer  
 (ADDRESS) Malta Bend, Mo

Filed 5/28/19 1912 G. A. Richard REGISTRAR ✓  
511

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Aug 16, 1912, to Sept 18, 1912, that I last saw him alive on Sept 18, 1912, and that death occurred, on the date stated above, at 100 m.

The CAUSE OF DEATH\* was as follows:  
Cancer of Bowels  
H6C  
for duration, do not know symptoms shown only for time of treatment  
 Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) F. W. Tuttle M.D. M. D.  
Sept 19, 1912 (Address) Mc Leonard

\*State the Disease Causing Death, or, in deaths from Violent Causes, (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 Blackburn Mo DATE OF BURIAL Sept 20, 1912

UNDERTAKER Geo H Hasemeier ADDRESS Blackburn

V. S. No. 22

# 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.)



REGISTRARS SHALL NOT RE-BUREAU OF VITAL STATISTICS  
 CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS  
 PRESCRIBED BY LAW. CERTIFICATE OF DEATH

PLACE OF DEATH  
 County Saline  
 Township Grand Pass  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 795 File No. \_\_\_\_\_  
 Primary Registration District No. 6038 Registered No. 27

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

FULL NAME William T. Lemen

## PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Oct. 2, 1883  
 (Month) (Day) (Year)

AGE 77 yrs. 11 mos. 16 ds. IF LESS than  
 1 day, \_\_\_\_ hrs.  
 or \_\_\_\_ min.?

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

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

NAME OF FATHER Robert Lemen

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

MAIDEN NAME OF MOTHER Margaret Osborne

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Lemen

(ADDRESS) Malta Bend, Mo.

Filed Nov 6 1912 H. A. Reichert REGISTRAR  
A. B. Brown

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 18, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 16, 1912, to Sept-18, 1912, that I last saw him alive on Sept. 18, 1912, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH\* was as follows:  
Cancer of Bowels  
As for duration do not know, symptoms showed only for treatment.  
As above stated  
 (Contributory) \_\_\_\_\_ (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) F. W. Little M. D.  
Sept. 19, 1912 (Address) Mt. Leonard

\*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 Blackburn, Mo. DATE OF BURIAL Sept. 20, 1912

UNDERTAKER Geo. H. Hasemier ADDRESS Blackburn

Original file, date. SEP 19, 1912 All information called for must be written on this Supplementary Certificate.

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Full name of informant 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.

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[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.)

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