

N. B.—Every item of information should be carefully supplied. PAGE 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.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <i>Female</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Married</i>	DATE OF DEATH <i>Sept 2, 1912</i> (Month) (Day) (Year)	
DATE OF BIRTH <i>Feb 1, 1875</i> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <i>August 22, 1912, to Sept 1, 1912,</i>	
AGE <i>37</i> yrs. <i>7</i> mos. <i>7</i> ds.			that I last saw her alive on <i>Sept 1, 1912,</i>	
OCCUPATION (a) Trade, profession, or particular kind of work <i>Housewife</i>			and that death occurred, on the date stated above, at <i>4 a.m.</i>	
(b) General nature of industry, business, or establishment in which employed (or employer)			The CAUSE OF DEATH* was as follows: <i>Tuberculosis</i> <i>23A</i>	
BIRTHPLACE (City or town, State or foreign country) <i>St Louis Mo.</i>			<i>Three</i> (Duration) <i>3</i> yrs. <i>0</i> mos. <i>0</i> ds.	
PARENTS	NAME OF FATHER <i>Joseph Kotrba</i>		Contributory (SECONDARY) <i>Do not know</i>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Bohemia</i>		(Duration) <i>0</i> yrs. <i>0</i> mos. <i>0</i> ds.	
	MAIDEN NAME OF MOTHER <i>Mary Kafka</i>		(Signed) <i>Wm Harrison</i> M. D.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Bohemia</i>		<i>Sept 2, 1912</i> (Address) <i>Marshall Mo.</i>	
*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			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
(Informant) <i>Anna Kaster</i>			At place of death <i>0</i> yrs. <i>0</i> mos. <i>0</i> ds. In the State <i>0</i> yrs. <i>0</i> mos. <i>0</i> ds.	
(ADDRESS) <i>Hollister Mo</i>			Where was disease contracted if not at place of death?	
Filed <i>Sept 2, 1912</i> <i>E. P. Whitford</i> REGISTRAR			Former or usual residence	
			PLACE OF BURIAL OR REMOVAL	
			DATE OF BURIAL	
			UNDERTAKER	
			ADDRESS	
			<i>Paul C. Steller</i> <i>Springfield Mo.</i>	

PLACE OF DEATH

County

Township

or

Village

or

City

(NO.

St.;

Ward)

FULL NAME

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

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

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*, *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.)



PLACE OF DEATH

County Taney
 Township Oliver
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

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

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

Registration District No. 860 File No. 4431736
 Primary Registration District No. 6630 Registered No. 71

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

FULL NAME

Josephine Horvath

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED married
 MARRIED WIDOWED OR DIVORCED
 (Write the word)

DATE OF BIRTH Feb. 1, 1875
 (Month) (Day) (Year)

AGE 37 yrs. 7 mos. 7 ds. IF LESS than
 1 day, ___ hrs. or ___ mins.

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) St. Louis, Mo.

NAME OF FATHER Joseph Peterba

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

MAIDEN NAME OF MOTHER Mary Kapka

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Kasten
 (ADDRESS) Hollister, Mo.

Filed Sept. 27 1912 E. P. Wittford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 2, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 22, 1912, to Sept. 1, 1912
 that I last saw her alive on Sept. 1, 1912
 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of the Lungs
 (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) Wm. Harrison M.D. Sept 2, 1912 (Address) Marshall, 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 St. Louis, Mo. DATE OF BURIAL Unknown 1912

UNDERTAKER Paul H. Stadler ADDRESS K Springfield

Original file, date _____ 19 _____

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

ORD

TH U

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