

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH			
County	<u>Marion</u>		Registration District No.	<u>549</u>	File No.	<u>33515</u>
Township	<u>Union</u>		Primary Registration District No.	<u>4024</u> <u>5747</u>	Registered No.	<u>9</u>
or			(NO. _____)	St. _____	Ward _____	(If death occurred in a hospital or institution, give its NAME instead of street and number)
Village						
or						
City						
FULL NAME <u>Carl Christian Schleimscher</u>						
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH			
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept 22, 1912</u> (Month) (Day) (Year)			
DATE OF BIRTH		AGE	I HEREBY CERTIFY, that I attended deceased from			
<u>Nov 11, 1837</u> (Month) (Day) (Year)		<u>74</u> yrs. <u>10</u> mos. <u>11</u> ds.	<u>Sept 20th, 1912, to Sept 21st, 1912,</u>			
		If LESS than 1 day, ___ hrs. or ___ min.?	that I last saw him alive on <u>Sept 21st, 1912,</u>			
OCCUPATION			and that death occurred, on the date stated above, at <u>3 A. M.</u>			
(a) Trade, profession, or particular kind of work		<u>Farmer</u>	The CAUSE OF DEATH* was as follows:			
(b) General nature of industry, business, or establishment in which employed (or employer)		<u>Farming</u>	<u>Bronchopneumonia</u> <u>16/17</u>			
BIRTHPLACE			(Duration) ___ yrs. ___ mos. ___ ds.			
(City or town, State or foreign country)		<u>Germany</u>	Contributory <u>None</u>			
PARENTS	NAME OF FATHER	<u>Carl C. Schleimscher</u>	(Duration) ___ yrs. ___ mos. ___ ds.			
	BIRTHPLACE OF FATHER	<u>Germany</u>	(Signed) <u>H. F. Rhoads</u> M. D.			
	MAIDEN NAME OF MOTHER	<u>Don't know</u>	<u>Sept 22, 1912</u> (Address) <u>Philadelphia</u>			
	BIRTHPLACE OF MOTHER	<u>Germany</u>	*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)	<u>W. E. Davis</u>		At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.			
(ADDRESS)	<u>Philadelphia, Pa.</u>		Where was disease contracted if not at place of death?			
Filed	<u>Oct 9, 1912</u>		Former or usual residence			
	<u>C. F. Thomas</u> REGISTRAR		PLACE OF BURIAL OR REMOVAL			
			<u>Bethany Cemetery</u>			
			DATE OF BURIAL			
			<u>Sept 23rd, 1912</u>			
			UNDERTAKER			
			ADDRESS			

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*, *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 Marion
Township Union
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 549 File No. 33575
Primary Registration District No. 5742 Registered No. 9

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

FULL NAME Carl Christian Schleiermacher

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Nov. 11</u> , 18 <u>37</u> (Month) (Day) (Year)		
AGE <u>74</u> yrs. <u>10</u> mos. <u>11</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>		

PARENTS	NAME OF FATHER <u>Carl C. Schleiermacher</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>
	MAIDEN NAME OF MOTHER <u>Elizabeth Krow</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Davis
(ADDRESS) Philadelphia, Mo.

Filed Oct 9 1922 B. P. Phillips
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 22, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Sept. 20, 1922, to Sept. 21, 1922
that I last saw him alive on Sept. 21, 1922,
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. F. Rhodes M. D.
Sept. 22, 1922 (Address) Philadelphia

*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 Bethany Cemetery DATE OF BURIAL Sept. 23, 1922

UNDERTAKER O. W. Pearson ADDRESS Phila. Mo.

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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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[Approved by U. S. Census and American Public Health Association]

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