

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
County Jasper
Township _____ or Village _____ or City Joplin (NO. 517 St. 7 Ward) Registration District No. 411 File No. 39601
Primary Registration District No. 2109 Registered No. 538
FULL NAME Hellen Manciehl (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Infant
DATE OF BIRTH Aug 2, 1911
(Month) (Day) (Year)
AGE 1 yrs. 4 mos. 21 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

PARENTS
NAME OF FATHER Wm Manciehl
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark
MAIDEN NAME OF MOTHER Edith Buss
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kans

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Burns
(ADDRESS) Joplin Mo
12/24 1912 W. J. Gregg
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 23, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 12, 1912, to Dec. 23, 1912, that I last saw him alive on Dec 23, 1912, and that death occurred, on the date stated above, at 5:20 p.m.

The CAUSE OF DEATH* was as follows:
108 Meningitis
798

(Duration) ___ yrs. ___ mos. 6 ds.
Contributory Pneumonia
(Duration) ___ yrs. ___ mos. 12 ds.
(Signed) Robert L. Keff M. D.
Dec 24, 1912 (Address) 274 Main

*State the Disease Causing Death, or, in deaths from Violence, Cause of (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 Fairview DATE OF BURIAL 12/24, 1912
UNDERTAKER The Frank Sievers Undertaking Co ADDRESS W. J. Gregg
J. P. Hancock

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.)

N. B.—If any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important.

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 Jasper
 Township _____
 or
 Village _____
 or
 City Joplin

Registration District No. 411 File No. _____
 Primary Registration District No. 2002 Registered No. 038

(No. 517 N. Sergeant St.; _____ Ward)

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

FULL NAME Hellen Manciehl

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Dec. 23, 1912
 (Month) (Day) (Year)

DATE OF BIRTH Aug. 2, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 12, 1912, to Dec. 23, 1912, that I last saw her alive on Dec. 23, 1912, and that death occurred, on the date stated above, at 5-20 m.

AGE 1 yrs. 4 mos. 21 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
Meningitis, Cerebro-Spinal

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

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

Contributory (SECONDARY) Lung Pneumonia
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Robt. L. Neff. M. D.
Dec. 24, 1912 (Address) 2207 Main

PARENTS
 NAME OF FATHER Wm. Manciehl
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark.
 MAIDEN NAME OF MOTHER Eddy Burns
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kans.

*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) C. E. Burns

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 _____

(ADDRESS) Joplin Mo.

PLACE OF BURIAL OR REMOVAL Fairview DATE OF BURIAL 12/24, 1912

Filed 12/24, 1912, A. M. Gregg. REGISTRAR

UNDERTAKER J. P. Frank ADDRESS Joplin

Revised United States Standard Certificate of Death

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

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