

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

18613

PLACE OF DEATH
County Saline
Township Cambridge
or
Village
or
City (NO. St. Ward)

Registration District No. 794 File No. 18613
Primary Registration District No. 1037A Registered No. 4

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

FULL NAME Katharina Schellenberg

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|---|--|
| SEX <u>Female</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> (Write the word) |
| DATE OF BIRTH <u>July 26, 1834</u> (Month) (Day) (Year) | | |
| AGE <u>78 yrs 9 mos 5 ds.</u> | | If LESS than 1 day, hrs. or min.? |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>not working</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>S-O</u> | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Schwaeringen, Wuerstenberg, Germany</u> | | |
| PARENTS | NAME OF FATHER <u>Paul Hegman</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u> | |
| | MAIDEN NAME OF MOTHER <u>not known</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u> | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 3, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 21, 1913, to May 3, 1913, that I last saw her alive on May 2, 1913, and that death occurred, on the date stated above, at 10 P. m. The CAUSE OF DEATH* was as follows:

Pathology
117
167 (Duration) yrs. mos. ds.
Contributory Senility (Duration) yrs. mos. ds.
(Signed) R. L. Miller M. D.
April 5, 1913 (Address) Gallatin, 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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Schellenberg
(ADDRESS)
Filed May 3, 1913 J. H. Dairlow REGISTRAR

PLACE OF BURIAL OR REMOVAL New Frankfurt Cemetery DATE OF BURIAL May 5, 1913
UNDERTAKER Doc Genser ADDRESS

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.

WHILE I LIVE, I WILL UNFADINGLY REMEMBER THIS IS A PERMANENT RECORD

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*, *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 *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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PLACE OF DEATH

County Saline
Township Cambridge
or
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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 794 File No. _____
Primary Registration District No. 6037a Registered No. 4

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

FULL NAME Katherina Schellenberg

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE _____ SINGLE Married Widowed Divorced Never Married Supplied.
(If ritc the word)

DATE OF DEATH _____, 1913
(Month) May (Day) 3 (Year)

DATE OF BIRTH _____, 1911
(Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911, that I last saw h _____ alive on _____, 1911.

AGE _____ yrs. _____ mos. _____ ds. Supplied. Supplied.
IF LESS than _____ day, _____ hrs. _____ min.

and that death occurred, on the date stated above at _____ m. The CAUSE OF DEATH* was as follows:

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

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

PARENTS NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Paul Schellenberg X
(ADDRESS) Lillian Ind X

Filed July 4 1913 J. H. Davidson REGISTRAR

CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____, 1911 (Address) _____

*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 _____ DATE OF BURIAL _____, 1911

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY Satisfactory Information Supplied.

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21981
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