

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

PLACE OF DEATH
County Buchanan
Township _____ Registration District No. 83 File No. 29043
or _____
Village _____ Primary Registration District No. 1001 Registered No. 830
or _____
City St Joseph (NO. 614 Charles St.: _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Belle Eiler

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH McH 23 1857
(Month) (Day) (Year)

AGE 56 yrs. 5 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work House Hold
(b) General nature of industry, business, or establishment in which employed (or employer) 9-30

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

PARENTS
NAME OF FATHER Mathes Eiler
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Veronika Wertz
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 2 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 30, 1913, to Sept 2, 1913, that I last saw h. alive on Sept 2, 1913, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Apoplexy;
Paralysis right side
131
92 H (Duration) ___ yrs. ___ mos. 1 ds.
Contributory Chronic suppurative
(SECONDARY) (Duration) 1 yrs. ___ mos. ___ ds.

(Signed) R. Thompson M. D.
Sept 3, 1913. (Address) St Joseph, 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) Lewis Streckelbein
(ADDRESS) 614 Charles

PLACE OF BURIAL OR REMOVAL St. Moral Conv. DATE OF BURIAL Sept 4 1913
UNDERTAKER W. Meierhoffen ADDRESS 824 Felix

Filed Sept 3 1913 R. Harrington REGISTRAR

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.

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 for which 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.)

N. B. 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 Buchanan County _____
 Registry shall not receive a fee for certificates until they are completed as prescribed by law.
 Township _____ Registration District No. 85 File No. _____
 or Village _____ Primary Registration District No. 1001 Registered No. 830
 or City St. Joseph (NO. 614 Charles St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]
 FULL NAME Belle Eiler

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH _____, 191 <u>3</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. _____ ds. Satisfactory Information Supplied.		
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ Satisfactory Information Supplied.		
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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 2, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 1913, that I last saw him alive on _____, 1913, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Apoplexy - Paralysis right side Hemiplegia
before base of brain
 (Duration) _____ yrs. _____ mos. _____ ds.
Chronic nephritis
 (SECONDARY) (Duration) 1 yrs. _____ mos. _____ ds.
 (Signed) J. S. Thourgon M. D.
Sept 9, 1913 (Address) St. Joseph, 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 _____	DATE OF BURIAL _____, 191 <u>3</u>
UNDERTAKER _____	ADDRESS _____

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 Satisfactory Information Supplied.
 (ADDRESS) _____

Filed Sept 3, 1913 J. W. E. Harrington REGISTRAR

Revised United States Standard Certificate of Death

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

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