

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

PLACE OF DEATH

County Wage
Township Crawford
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 640 File No. 30504
Primary Registration District No. 5849 Registered No. 27

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

FULL NAME

Trecie Marine Feilmann

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH July 3rd, 1913
(Month) (Day) (Year)
AGE _____ yrs. 2 mos. 16 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

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

PARENTS
NAME OF FATHER Henry J Feilmann
BIRTHPLACE OF FATHER (City or town, State or foreign country) Richfountain Mo.
MAIDEN NAME OF MOTHER Sophia Duncan
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Flora Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J Feilmann
(ADDRESS) Linn Mo.

Filed Sept 20, 1913 H. S. Howe
REGISTRAR

21 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 19th, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 5th, 1913, to Sept 19, 1913, that I last saw her alive on Sept 7, 1913, and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Marasmus
34
158 (Duration) _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. Jett M. D.
Sept 19, 1913 (Address) Linn 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 Linn Mo. DATE OF BURIAL Sept 20, 1913
UNDERTAKER A. J. Biollat ADDRESS Linn Mo.

L.Y. PHYSICIANS should be notified 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 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.)

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

N. B.—Every item of information should be carefully checked to see that it is correct. OCCUPATION is very important. It may be properly classified if it is not.

PLACE OF DEATH

County

Osage Crawford

Township

or Village

or

City

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

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

Registration District No.

640

File No.

Primary Registration District No.

5849

Registered No.

27

(NO.)

St.:

Ward)

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

FULL NAME

Frederic Marine Zilmann

PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

A

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

Single

DATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

Sept-19-1913 (Month) (Day) (Year)

DATE OF BIRTH

Satisfactory Information Supplied

AGE

IF LESS than 1 day, hrs. or min. yrs. mos. ds.

I HEREBY CERTIFY that I attended deceased from (Month) (Day) (Year) to (Month) (Day) (Year) and that I last saw him alive on (Month) (Day) (Year) and that death occurred, on the date stated above, at (Month) (Day) (Year) m.

OCCUPATION (a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows: Marasmus by philes

BIRTHPLACE (City or town, State or foreign country)

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)

Contributory (SECONDARY)

(Duration) yrs. mos. ds. (Signed) J. L. Lehn M.D. Sept 19/13 (Address) Lehn M.D.

*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)

(ADDRESS)

Filed

Oct 8 1913 H.S. Dovel

REGISTRAR

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Original file, date

SEP 1913

19

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

Revised United States Standard Certificate of Death

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

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30504
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