

INK THIS IS A PERMANENT RECORD

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: Butler
Township: Ash Hill
or
Village: Quincy
or
City: _____ (NO. _____ St. _____ Ward _____)

Registration District No. 92 File No. 2635539
Primary Registration District No. 5134B Registered No. _____

FULL NAME Anton Chas. Luternt [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>March 13, 1866</u> (Month) (Day) (Year)		
AGE <u>47 yrs. 8 mos. 3 ds.</u>		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer - Dr</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>		
PARENTS	NAME OF FATHER <u>Herman Luternt</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>	
	MAIDEN NAME OF MOTHER <u>Otilie Funk</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Nov 30, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 29, 1913, to Nov 30, 1913, that I last saw him alive on Nov 29, 1913, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:
Asphyxia
108
111 B

(Duration) _____ yrs. _____ mos. 10 ds.
Contributory Edema of Lung
(SECONDARY) (Duration) _____ yrs. 3 mos. _____ ds.

(Signed) Scott Leach M. D.
Nov 30, 1913 (Address) Quincy 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 REGENT 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) Frank Luternt
(ADDRESS) Quincy mo
Filed Nov 30, 1913 Tom Lutzer REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Carroll Cemetery</u>	DATE OF BURIAL <u>Dec 1913</u>
UNDERTAKER <u>Henry Phillips</u>	ADDRESS <u>Quincy Mo</u>

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) *Colton 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 *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.)

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the USE OF DEAD H 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 Butter
 County Butter
 Township ash Hill
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward) _____

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

Registration District No. 92 File No. _____
 Primary Registration District No. 5134 B Registered No. 26

FULL NAME Anton Chas Leuter

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

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> <small>(Write the word)</small>
DATE OF BIRTH _____ <small>(Month) (Day) (Year)</small>		
AGE _____ <small>mos. ds.</small>		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) _____		
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 <u>11-30</u> , 191 <u>3</u> <small>(Month) (Day) (Year)</small>
I HEREBY CERTIFY, that I attended deceased from <u>11-29</u> , 191 <u>3</u> , to <u>11-30</u> , 191 <u>3</u> , that I last saw him alive on <u>11-29</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>80</u> m.
The CAUSE OF DEATH* was as follows: <u>Asphyxia, due to Pulmonary Oedema.</u>
(Duration) _____ yrs. _____ mos. <u>10</u> ds.
Contributory (SECONDARY) <u>Edema of Lungs</u> (Duration) _____ yrs. <u>3</u> mos. _____ ds.
(Signed) <u>Paul Leuter</u> M. D. <u>11-30</u> , 191 <u>3</u> (Address) <u>Quincy Mo</u>
*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 _____

THE [ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____

Filed 11-30, 1913, Paul Leuter
 REGISTRAR

Revised United States Standard Certificate of Death

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

35533

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