1 PLACE OF DEATH.

County Barton

Township SW

or

City ✓

No. Reg. Dis 42 Primary Dis 5064 street, Ward.

Registered No. 7 91

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

2 FULL NAME Mary Schneider

~~STATE OF KANSAS.~~ Mo

STATE BOARD OF HEALTH.

STANDARD CERTIFICATE OF DEATH.

3

PERSONAL AND STATISTICAL PARTICULARS.

3 Sex F

4 Color or Race. White

5 Single, Married, Widowed, or Divorced. (Write the word.) widowed

6 Date of Birth. 5 (Month) 16 (Day) 41 (Year)

7 Age. 72 yrs. 5 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

8 Occupation.

(a) Trade, profession, or particular kind of work. Housewife

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

9 Birthplace. (State or country). Switzerland

Parents.

10 Name of Father. Conrad Eikels

11 Birthplace of Father. (State or country). Switzerland

12 Maiden name of Mother. Mina Cartel

13 Birthplace of Mother. (State or country). Switzerland

14 The above is true to the best of my knowledge.

(Informant) Elmer Schneider

(Address) Opolis Ks

15 Filed 1/19 1914 ✓ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16 Date of Death. 1 (Month) 17 (Day) 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1913, to Jan 16 1914, that I last saw her alive on 1/16 1914 and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH * was as follows:

Fracture of Femur

186A

194B

16 ✓ (Duration) ___ yrs. 3 mos. ___ ds.

Contributory (Secondary). Age & general debility

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W A McKelvy M. D.

1/18 1914 (Address) Mindenis Mo

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 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

19 Place of Burial or Removal. Block Jack ✓

Date of Burial. 1/18 1914

20 Undertaker. Bowman

Address. Pittsburg Ks

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. See instructions on back of certificate.

3-5380

UNFADING INK—THIS

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 *septichaemia*," "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.)

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

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

PLACE OF DEATH

County: Barton

Township: S. W.

or

Village:

or

City: (NO. St.; Ward)

Registration District No.: 42

Primary Registration District No.: 5-064

File No.:

Registered No.: 1

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

FULL NAME Mary Schneider

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W

SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Factory Information Supplied (Month) (Day) 1 (Year)

AGE: Factory Information Supplied yrs. mos. 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): Factory 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):

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Factory Information Supplied

(ADDRESS):

Filed: 1/20, 1914 Geo. Jp Nish M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan. 17, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Factory Information Supplied, 191, to , 191, that I last saw h alive on , 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Fracture of Femur
Accidental by fall
Not intubated

(Duration) yrs. mos. ds.

Contributory (SECONDARY): Age + Gen. Debility

(Duration) yrs. mos. ds.

(Signed) X Wm McKelvey M. D.

1/18, 1914 (Address) Minden Mines, 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: Factory Information Supplied

DATE OF BURIAL: 191

UNDERTAKER

ADDRESS

SUPPLEMENTARY

Original file, date JAN 1914, 19 All information called for must be written on this Supplementary Certificate.

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.

WRITE PLAINLY

Revised United States Standard Certificate of Death

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

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