

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

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.

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

PLACE OF DEATH Missouri
County West
Township East Springfield
Village _____
City _____ (NO. _____ St.; _____ Ward)
Registration District No. 266 File No. 22267-2
Primary Registration District No. 5-370 Registered No. 67

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

FULL NAME Denise Landiger

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OF RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH not known
AGE about 63 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work County Inmate
(b) General nature of industry, business, or establishment in which employed (or employer)
BIRTHPLACE (City or town, State or foreign country) not known
PARENTS
NAME OF FATHER W.H. Landiger
BIRTHPLACE OF FATHER (City or town, State or foreign country) not known
MAIDEN NAME OF MOTHER not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country) not known

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 24, 1914
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from July 17, 1914, to July 23, 1914, that I last saw him alive on July 23, 1914, and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows:
Acute Dysentery
130
14
(Duration) _____ yrs. _____ mos. 7 ds.
Contributory (SECONDARY)
Education _____ yrs. _____ mos. _____ ds.
(Signed) A. T. McWhorter M. D.
July 24, 1914 (Address) Salisbury
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Judge Pressel
(ADDRESS) Salisbury
Filed July 24, 1914. J. H. Welch
REGISTRAR

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 2 yrs. _____ mos. _____ ds. In the _____ State 30 yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? at place of death
Former or usual residence _____
PLACE OF BURIAL OR REMOVAL Stagener Cem.
DATE OF BURIAL July 25, 1914
UNDERTAKER _____ ADDRESS _____

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, 8 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.)

PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty St. LouisTownship East Spring CreekRegistration District No. 266

File No. _____

Village _____

Primary Registration District No. 5370Registered No. 67

City _____ (NO. _____)

St. _____ Ward _____

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

FULL NAME Stuie Landigan

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)DATE OF BIRTH _____, 191____
(Month) (Day) (Year)AGE _____ 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) _____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) _____

(ADDRESS) _____

Filed July 24 19114 H. J. G. Welch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 24, 19114
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____,

and that death occurred, on the date stated above, at 5 PM.

The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs. _____ mos. _____ ds.Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) _____ M. D.
_____, 191____ (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 Cedar Grove DATE OF BURIAL 7/25 19114UNDERTAKER John C. Jones ADDRESS Salem MoOriginal file, date July 24 19114 All information filed for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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