

## PLACE OF DEATH

County

Lawrence

Township

Freistattor  
Village

or

City

(NO. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_)

Registration District No. 473File No. 823171Primary Registration District No. 5637Registered No. 8

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

## FULL NAME

Gottlieb Gliedt

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OR RACE

WhiteSINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)married

DATE OF DEATH

July 7

(Month)

(Day)

1914  
(Year)

DATE OF BIRTH

April 14, 1842

(Month)

(Day)

(Year)

AGE

72 yrs. 2 mos. 23 ds.If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.?I HEREBY CERTIFY, that I attended deceased from June 22, 1914, to July 6, 1914, that I last saw him alive on above date, 1914, and that death occurred, on the date stated above, at 2:11 A.M.

The CAUSE OF DEATH\* was as follows:

Embolism

OCCUPATION

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

Farmer

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

outdoors

BIRTHPLACE

(City or town, \_\_\_\_\_)

State or foreign country)

Germany

PARENTS

NAME OF FATHER

Herman Gliedt

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Germany

MAIDEN NAME OF MOTHER

Anna Steffen

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. M. Bröckschmidt

(ADDRESS)

Monett Mo

Filed

July 7<sup>th</sup>, 1914H. F. Weiser

REGISTRAR

Contributory

(SECONDARY)

(Duration) \_\_\_\_\_

yrs. \_\_\_\_\_

mos. \_\_\_\_\_

ds. \_\_\_\_\_

(Signed)

Carlos Copeland

M. D.

July 7, 1914

(Address)

Freistatt 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

Freistatt Cemetery

DATE OF BURIAL

July 8, 1914

UNDERTAKER

R. M. Callaway

ADDRESS

Monett Mo

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.

**PLACE OF DEATH**

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

County \_\_\_\_\_  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_)

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

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX	COLOR OR RACE	SINGLE	DATE OF BIRTH
		MARRIED	
		WIDOWED	(Month) _____ (Day) _____ (Year) _____
		OR DIVORCED	IF LESS than
		(Write the word)	1 day, _____ hrs.
			or _____ min.?
			_____ yrs. _____ mos. _____ ds.

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) \_\_\_\_\_

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 \_\_\_\_\_, 191\_\_\_\_, REGIS. # \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_, 191\_\_\_\_, (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I 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 \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_

(Address) \_\_\_\_\_ 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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

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

PLACE OF DEATH  
County Lawrence  
Township Freistatt  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 473 File No. \_\_\_\_\_  
Primary Registration District No. 5637 Registered No. \_\_\_\_\_

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

FULL NAME Gottlieb Gliedt

**PERSONAL AND STATISTICAL PARTICULARS**

SEX M COLOR OR RACE W SINGLE Married MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ pr. \_\_\_\_\_ 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 July 7 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 1914, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1914, and that death occurred, on the date stated \_\_\_\_\_ at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia and Thrombosis

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Charles Copeland M.D. (M. D.)  
July 7 1914 (Address) Freistatt 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) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_  
FILED July 7 1914 A. E. Waisie REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1914

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
Supplied

SATISFACTORY INFORMATION SUPPLIED

SUPPLEMENTARY INFORMATION SUPPLIED

# 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*, *Composer*, *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

23171

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.)