

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

PLACE OF DEATH -

County Franklin

Township _____

or _____

Village _____

or _____

City Washington (NO. _____ St.: _____ Ward)

Registration District No. 297

File No. 25811

Primary Registration District No. 316

Registered No. 43

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

FULL NAME Henry F. Watermann

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Married
(If rite the word)

DATE OF BIRTH Oct 17, 1879
(Month) (Day) (Year)

AGE 34 yrs. 9 mos. 10 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Bottling & making Soda
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer in the Washington Bottling Co.

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

NAME OF FATHER Chas. Watermann

BIRTHPLACE OF FATHER (City or town, State or foreign country) Europe

MAIDEN NAME OF MOTHER Elizabeth Herman

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Watermann

(ADDRESS) City

FILED Aug 7, 1914 D. A. Deibert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 6, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 20, 1914, to Aug 6, 1914, that I last saw him alive on Aug 6, 1914, and that death occurred, on the date stated above, at 9:10 m.

The CAUSE OF DEATH* was as follows:
Preparating Peptic Ulcers
129
1180
(Duration) 1 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G. L. Munch M. D.
Aug 7, 1914 (Address) Washington 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 34 yrs. 9 mos. 10 ds. State

Where was disease contracted If not at place of death?

Former or usual residence in Washington Mo.

PLACE OF BURIAL OR REMOVAL St. Peters Cemetery DATE OF BURIAL Aug 9, 1914

UNDERTAKER Bleshmann & Co ADDRESS Washington 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.

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

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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County

Franklin

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

Township

Registration District No.

File No.

Village

Primary Registration District No.

Registered No.

City

St.: Ward)

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

FULL NAME

Henry F. Waterman

297
3016
43

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *M* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED *M*
(If ritc the word)

DATE OF DEATH

Aug 6, 191*4*
(Month) (Day) (Year)

DATE OF BIRTH

Satisfactory Information Supplied
(Day) (Year)

AGE

If LESS than day hrs. or min. yrs. mos. ds.

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h alive on _____, 191____,

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:

Perforating Peptic Ulcers, Peritonitis
111
(Duration) yrs. mos. ds.

BIRTHPLACE

(City or town, State or foreign country)

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(Signed) *W. J. Munn*
191____ (Address) *Washington 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)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filed

Oct 3, 191*4*

H. A. Leibert
REGISTRAR

UNDERTAKER

ADDRESS

Original file, date

AUG 1914

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

SUPPLEMENTARY
Satisfactory Information Supplied

EMMENTARY
Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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