

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

PLACE OF DEATH
County St. Francois
Township Peery
or
Village
or
City Bonneterre

Registration District No. 775 File No. 27297
Primary Registration District No. 6020 Registered No. 47
St.: _____ Ward) _____

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

FULL NAME Kate Lesser

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH January 11, 1872
(Month) (Day) (Year)
AGE 42 yrs. 11 mos. 0 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

DATE OF DEATH August 11, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August 10, 1914, to August 11, 1914, that I last saw her alive on August 10, 1914, and that death occurred, on the date stated above, at 4:50 AM.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning.

OCCUPATION
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

120
132 B
(Duration) _____ yrs. _____ mos. 1 ds.

BIRTHPLACE (City or town, State or foreign country) St. Francois Co. Mo.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Seeley M. D.
8-11, 1914 (Address) Bonneterre

PARENTS
NAME OF FATHER Herman Wagner
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER May Heinrich
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

*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) J. Lesser
(ADDRESS) Bonne Terre

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 _____

Filed Aug 11, 1914 T. Olson
REGISTRAR

PLACE OF BURIAL OR REMOVAL Bonneterre Cemetery DATE OF BURIAL Aug 12, 1914
UNDERTAKER P. A. Binham ADDRESS Bonneterre 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, 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, 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 DESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County St. Francois
Township Perry
Village _____
City _____ (NO _____ St.: _____ Ward)

Registration District No. 775 File No. _____
Primary Registration District No. 6020 Registered No. 47

FULL NAME Kate Lesser

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____
(Month) _____ (Day) 1 (Year) _____

AGE _____
If LESS than 1 day, _____ hrs. or _____ min. _____ yrs. _____ mos. _____

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 Oct 4 1914 T. A. Son
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 11 1914
(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____ 191____, to _____ 191____, that I last saw h _____ alive _____ 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Wraemic Poisoning
Berte Kephik's
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) T. A. Son M. D.
8-11 1914 (Address) Some Town 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 _____
DATE OF BURIAL _____ 191____

UNDERTAKER _____
ADDRESS _____

SUPPLEMENTARY Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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