

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

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City St Louis

Registration District No. 791

Primary Registration District No. 1003

(No. St Johns Hospital St. 75 Ward)

File No. 27584

Registered No. 7597

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

FULL NAME Emily Neiserer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Aug 10, 1914
(Month) (Day) (Year)

DATE OF BIRTH Oct 31, 1891
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1914, to Aug 10, 1914, that I last saw him alive on Aug 10, 1914, and that death occurred, on the date stated above, at 9 a.m.
The CAUSE OF DEATH* was as follows:

AGE 22 yrs. 9 mos. 11 ds. If LESS than 1 day, ____ hrs. or ____ min.?

Heart Failure ✓
66 D (Duration) ____ yrs. ____ mos. ____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home

BIRTHPLACE (City or town, State or foreign country) Missouri

NAME OF FATHER Clement Neiserer

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

MAIDEN NAME OF MOTHER Mary Schaff

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

Contributory Epileptic Disease (Secondary)
9 1/2 (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) John L. Tierney M. D.
Aug 10, 1914 (Address) St Johns Hosp

*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) Mary Neiserer
(ADDRESS) St Genevieve Mo

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death: ____ yrs. ____ mos. 10 ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?
Former or usual residence St Genevieve Mo

PLACE OF BURIAL OR REMOVAL St Genevieve Mo DATE OF BURIAL Aug 10, 1914

Filed 1914 Marb Starkopf REGISTRAR

UNDERTAKER Duffy, Hillman & Co ADDRESS 4429 E. actn

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, 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.)

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

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____
Township _____
or
Village _____
or
City _____ (NO. _____)

Registration District No. 791
Primary Registration District No. 1003

File No. _____
Registered No. 7597

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

FULL NAME Emily Weiser

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF FACE W SINGLE MARRIED WIDOWED OR DIVORCED S. (Write the word)

DATE OF BIRTH _____ (Day) _____ (Year) _____ (Info) Satisfactory Information Supplied

AGE _____ yrs. _____ mos. _____ ds. If LESS than _____ hrs. _____ min. 2

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 12-17 1914 A. G. Drogosz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ 1914 (Month) Aug. (Day) 18 (Year)

I HEREBY CERTIFY, that I attended deceased from _____ 1914, to _____ 1914, that I last saw h _____ alive _____ 1914.

and that death occurred, on the date _____, at _____ m.

The CAUSE OF DEATH* was as follows:

Heart Failure
Acute Dilatation of Heart

Contributory (SECONDARY) Exophthalmic Goiter
(Duration) _____ yrs. _____ mos. _____ ds.
(Sign) John S. Drogosz M.D.
(Address) St. John Hosp.

*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 _____ 1914

UNDERTAKER _____ ADDRESS _____ Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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