

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....

Registration District No. 1008File No. 37467Primary Registration District No. 1008Registered No. 10762

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

FULL NAME Fredrick J Backer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>July</u> (Month) <u>14</u> (Day) <u>1868</u> (Year)		
AGE <u>46</u> yrs. <u>10</u> mos. <u>12</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Flour Packer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Comm meal mill</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Milwaukee Ills</u>		
PARENTS	NAME OF FATHER <u>Fred Backer</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>	
	MAIDEN NAME OF MOTHER <u>Mary Miller</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ills</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Backer(ADDRESS) 1348 Chouteau

Filed

NOV 29 1914Max Loebstark

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 24th, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov. 3rd, 1914, to Nov. 25th, 1914, that I last saw him alive on Nov. 25th, 1914, and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:Consumption Tuberculosis2.3A / 1000 (Duration) 6 yrs. 6 mos. 28 ds.Contributory Branchitis (SECONDARY) (Duration) 9 yrs. 9 mos. 9 ds.(Signed) Jas. C. Lebecht M. D.
11-27 1914 (Address) 1509 Chouteau

*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

St. Peter Paul

UNDERTAKER

Frank Neelke

DATE OF BURIAL

Nov 30, 1914

ADDRESS

907 Chouteau

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, 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.)

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

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

CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(No. _____)

St. _____

Ward _____

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

FULL NAME Frederick J. Backer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MCOLOR OF RACE W

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

M

DATE OF BIRTH _____

(Month) _____

(Day) _____

(Year) _____

AGE _____

IF LESS than
1 day, hrs. _____
or min. _____

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) _____

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 Jan. 4 1915

REGISTRAR

DATE OF DEATH Nov 26 1914

(Month) _____

(Day) _____

(Year) _____

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

that I last saw him alive on _____, 191____,

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

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Acute Bronchitis

Contributory

(SECONDARY)

Information supplied by _____

(Signed) Dr. Lebrecht with phone 11/27 191____

Duration _____

yrs. _____

mos. _____

ds. _____

(Address) 1509 Chatter Box

*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 _____

Original file, date NOV 1914

1914

19

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

Revised United States Standard Certificate of Death

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

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