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

38182

PLACE OF DEATH

County: Cape Girardeau

Township: Randol

or Village:

or City: (NO. ____ St.: ____ Ward)

Registration District No. 131

Primary Registration District No. 5182

File No.

Registered No. 11

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

FULL NAME: Ella Rosina Kirchhoff

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: March (Month) 23 (Day), 1895 (Year)

AGE: 19 yrs. 9 mos. 8 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Randol Twp Cape Co

PARENTS

NAME OF FATHER: Hermann H. Kirchhoff

BIRTHPLACE OF FATHER (City or town, State or foreign country): Randol Twp.

MAIDEN NAME OF MOTHER: Mary E. Klostermann

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Randol Twp

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): H H Kirchhoff

(ADDRESS): Cape Girardeau

Filed Dec 31st, 1914. D. G. Seibert, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 31st (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 6th, 1914, to Dec 31st, 1914, that I last saw her alive on Dec 30th, 1914, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Trichinosis

42A

(Duration) ___ yrs. ___ mos. 25 ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) D. G. Seibert M. D.

Dec 31st, 1914 (Address) Egypt Mills, 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: Kirchhoff Cemetery

DATE OF BURIAL: 1-2, 1915

UNDERTAKER: Al Brinkapf

ADDRESS: Cape Girardeau Mo

...Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor...

ed 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 *septichaemia*," "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.)

N. B.—Every item of information should be carefully supplied. AGE should be given in years, months and days. Place of DEATH should be given in full, including name of hospital, or street and number, and city, township or village, and county, and state. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County: Cape Girardeau

Township: Jackson

or Village:

or City: (NO. ____ St.: ____ Ward)

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

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

Registration District No. 131 — File No.

Primary Registration District No. 5182 — Registered No. 11

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

FULL NAME Ella Rosina Knickhoff

PERSONAL AND STATISTICAL PARTICULARS

SEX: F — COLOR OR RACE: W — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): S

DATE OF BIRTH: ____ (Month) ____ (Day) 1 (Year)

AGE: ____ yrs. ____ mos. ____ ds. — If LESS than 1 day, ____ hrs. or ____ 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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(ADDRESS) ____

Filed 12/31, 1914 D. G. Leiber
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec 31, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied, 1914 to ____, 191__, that I last saw h____ alive on ____, 191__, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Trichinosis
from eating raw pork sausage containing Trichina

____ (Duration) ____ yrs. ____ mos. 25 ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) D. G. Leiber, Egypt Mills, Mo. M. D.
12/31, 1914 (Address) D. G. Leiber

*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.

Original file, date ____, 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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