

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

6983

PLACE OF DEATH  
County Saline  
Township Spannbrieger  
or William  
Village  
or  
City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 774 File No. \_\_\_\_\_  
Primary Registration District No. 60374 Registered No. 4

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

FULL NAME Mary Magdalena Gable

PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White **SINGLE** Married  
**MARRIED**  
**WIDOWED**  
**OR DIVORCED**  
(If not the word)

DATE OF DEATH February 14, 1915  
(Month) (Day) (Year)

DATE OF BIRTH October 30, 1844  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 26, 1914, to Feb. 14, 1915, that I last saw her alive on Feb. 14, 1915, and that death occurred, on the date stated above, at 12 m.

AGE 70 yrs. 3 mos. 16 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) 126 114

Gall. Stone  
(Duration) 1 yrs. 1 mos. 3 ds.  
Contributory

BIRTHPLACE Waldbockelheim  
(City or town, State or foreign country) Germany

NAME OF FATHER Fred Portenheimer

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

MAIDEN NAME OF MOTHER not known

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

(Signed) R. H. Miller M. D.  
2/14, 1915 (Address) William Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert M. Katta

(ADDRESS) Slater

Filed Feb 17, 1915 REGISTRAR

\*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 New Frankfurt Cem. DATE OF BURIAL Feb 18, 1915

UNDERTAKER J. Genser ADDRESS William Mo.

[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.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain, concise terms, so that it may be properly classified. Exact statement of OCCUPATION is required.

PLACE OF DEATH

County Saline  
 Township Caubridge  
 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. 194 File No. \_\_\_\_\_  
 Primary Registration District No. 6037 Registered No. 1

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

FULL NAME Mary M. Gable

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH \_\_\_\_\_ 2 - 16, 1916  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1916, to \_\_\_\_\_, 1916, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 1916, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The CAUSE OF DEATH\* was as follows:  
Satisfactory information supplied.

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) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Contributory (SECONDARY) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ M. D.  
 \_\_\_\_\_ 1916 (Address) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_

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 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 Feb 10 1916 J. H. Davidson  
 REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1916  
 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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