

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  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

PLACE OF DEATH  
County Lafayette  
Township Middleton  
or  
Village Naworsky  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 460 File No. 13185  
Primary Registration District No. 4278 Registered No. 0

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

FULL NAME Johan Heinrich Kalthoff

**PERSONAL AND STATISTICAL PARTICULARS**

SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED W  
(Write the word)

DATE OF BIRTH Jan 10, 1879  
(Month) (Day) (Year)

AGE 76 yrs. 3 mos. 4 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

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

PARENTS  
NAME OF FATHER Johan Heinrich Kalthoff  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Buer Germany  
MAIDEN NAME OF MOTHER Blara Elizabeth Meier  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Buer Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) William J. Kalthoff  
(ADDRESS) Naworsky Mo.

Filed 4-16 - 1915 Geo. B. Williamson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH 4 14, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 4-9, 1915, to 4-13, 1915, that I last saw him alive on 4-13, 1915, and that death occurred, on the date stated above, at 10:25 AM.

The CAUSE OF DEATH\* was as follows:  
Bronchitis + La Grippe  
IIA  
1060

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 7 ds.

(Signed) W. J. Kalthoff M. D. 4-14, 1915 (Address) Alma 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 Herman Grange Land DATE OF BURIAL 4-17, 1915  
Alma Mo.  
UNDERTAKER Tom Laudrum ADDRESS Naworsky Mo.

# 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, Composer, 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.)

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

PLACE OF DEATH Lafayette County  
Township or Village or City Hannaly

Registration District No. 465  
Primary Registration District No. 4278  
File No.  
Registered No. 5  
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Johan N. Kaetoff

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE If LESS than 1 day, hrs or min. yrs. mos. 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 BIRTHPLAOF OF FATHER MAIDEN NAME OF MOTHER BIRTHPLAOF OF MOTHER

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

(ADDRESS) Filed 4/16 1915 S. B. Helanow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 4/14 1915 (Month) (Day) (Year)

Satisfactory CERTIFY, that I attended deceased from Information Supplied. What I last saw h. alive on and that death occurred, on the date stated above, 11:20 P.M.

The CAUSE OF DEATH was as follows: Bronchitis & Asphyxia

How could the disease have been contracted? How long was the man sick before the man was sick (but exact date) mos. ds. (Signed) 4/14 1915 (Address) S. B. Helanow

\*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 age of death yrs. mos. ds. In the State yrs. mos. ds. Where was contracted if not at place of death? Former or usual residence.

PLACE OF BURIAL OR REMOVAL STATE OF BURIAL

UNDERTAKER ADDRESS

