

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

1 PLACE OF DEATH

County

Township

Village

City

Registration District No.

Primary Registration District No.

(NO.

St.

Ward)

File No.

Registered No.

13609

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

2 FULL NAME

Estella Marie Batene

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Dec
(Month)

5
(Day)

1915
(Year)

7 AGE

4 yrs. 4 mos. 1 ds.

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

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(City or town, State or foreign country)

Perry Co. Mo.

10 NAME OF FATHER

Otto Batene

11 BIRTHPLACE OF FATHER

Perry Co. Mo.

12 MAIDEN NAME OF MOTHER

Lauretta Faries

13 BIRTHPLACE OF MOTHER

Perry Co. Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otto Batene

(Address)

Merfros Mo.

15

Filed

4-8

1915

K. C. Garner

Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4
(Month)

6
(Day)

1915
(Year)

17 I HEREBY CERTIFY, that I attended deceased from

April 3, 1915, to April 6, 1915,

that I last saw her alive on April 6, 1915,

and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

9

107A

(Duration)

yrs.

mos.

4

ds.

CONTRIBUTORY (Secondary)

Whooping Cough

(Duration)

yrs.

mos.

5

weeks

(Signed)

W. H. Altmeyer

M. D.

April 6, 1915

(Address)

Merfros Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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

19 PLACE OF BURIAL OR REMOVAL

Calhoun Cem. Croasstown

DATE OF BURIAL

4-7, 1915

20 UNDERTAKER

F. Grinand

ADDRESS

Croasstown

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. All information should be carefully checked. EXACTLY. PHYSICIANS should state

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 "*Assthenia*," "*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.)

County Perry
Township Saline
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 662 File No. _____
Primary Registration District No. 5880 Registered No. 6

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

FULL NAME Estelle Marie Carter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) 4-6 1915

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

HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied, 1915, that I last saw h. _____ alive on _____, 1915, and that death occurred, on the date stated above, at 120. The CAUSE OF DEATH* was as follows:

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) _____

Pneumonia (Bronch)
(Duration) _____ yrs. _____ mos. _____ ds. 4
Contributory Whooping Cough (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) W H Abmuthy M. D. 4/6 1915 (Address) Neufre

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____ Filed 4/6 1915 W H Abmuthy 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 _____ DATE OF BURIAL _____ UNDERTAKER, F. Guinand ADDRESS Ceras town Mo

N. B. - Every statement of OCCUPATION is very important. If it should be in plain terms, so that it is understood, it should be so stated.

Satisfactory Information Supplied

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