

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

PLACE OF DEATH

County Platte

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Weston (NO. \_\_\_\_\_)

Registration District No. 398

File No. 19751

Primary Registration District No. 4426

Registered No. 26

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

FULL NAME Alice Schneider

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)

DATE OF DEATH June 27, 1915  
(Month) (Day) (Year)

DATE OF BIRTH Jan 30, 1846  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 20, 1915, to June 27, 1915

AGE 68 yrs. 11 mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

that I last saw her alive on June 17, 1915 and that death occurred, on the date stated above, at 2:18 p.m.

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

The CAUSE OF DEATH\* was as follows: Aræmia

BIRTHPLACE (City or town, State or foreign country) Peunasee

131. 132 13 (Duration) \_\_\_\_\_ mos. 4 ds.

NAME OF FATHER Geo. B. Halley

Contributory (SECONDARY) Nephritis

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

(Duration) undetermined yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

MAIDEN NAME OF MOTHER Lynda Knapp

(Signed) Frank A. Calvert M. D.

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

(Address) Weston Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. V. Schneider

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

(ADDRESS) Weston Mo

LENGTH OF RESIDENCE (FOR HOUSEHOLD RESIDENTS, TRANSIENTS, OR RECENT RESIDENTS) At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Filed June 28, 1915 J. W. Smith REGISTRAR

Where was disease contracted If not at place of death? \_\_\_\_\_ Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Laurel Hill DATE OF BURIAL June 28, 1915  
UNDERTAKER J. H. Brice ADDRESS Weston Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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, 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 "Asthénia," "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.)

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County State Registration District No. 698 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ or \_\_\_\_\_ Village Weston Primary Registration District No. 4420 Registered No. 26  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 FULL NAME Alice Schneider

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED M.  
 (Write the word)  
 6 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
 7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.?  
 8 OCCUPATION  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

16 DATE OF DEATH \_\_\_\_\_ June 27, 1915  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 1915 to \_\_\_\_\_ 1915  
 that I last saw him \_\_\_\_\_ 1915  
 and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 The CAUSE OF DEATH\* was as follows:  
Art. Intestinal Hepatitis and Pneumia

9 BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_  
 10 NAME OF FATHER \_\_\_\_\_  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
 12 MAIDEN NAME OF MOTHER \_\_\_\_\_  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

CONTRIBUTORY (Secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) James C. Groat M. D.  
June 28, 1915 (Address) Weston, Mo.

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

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 \_\_\_\_\_

15 Filed June 27, 1915 J. W. Shultz Registrar

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 1915  
 20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Satisfactory Information Supplied

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Every item of information should be carefully classified. Name, sex, age should be carefully classified. Name, sex, age should be carefully classified.

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19751  
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