

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

1 PLACE OF DEATH

County Cass

Township _____
or _____

Registration District No. 213-

File No. 27170

Village _____

Primary Registration District No. 3014-

Registered No. 146-

City Jefferson

(NO 1118 E High St. Ward)

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

2 FULL NAME Anna Helena DeBrine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Aug. 4, 1854
(Month) (Day) (Year)

7 AGE 61 yrs. 27 mos. 27 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Cole Co. Mo.

PARENTS
10 NAME OF FATHER John Racker
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
12 MAIDEN NAME OF MOTHER Cathrine Talken
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John DeBrine
(Address) Jefferson City, Mo.

15 Filed Sept. 1- 1915. W. B. Bedford
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 1st 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 19____ to _____ 19____, that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Heart failure
8 1/2
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. E. Keller M. D.
(Address) Lohman 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 St. Peter's Cemetery, Jeff. City Mo. DATE OF BURIAL 1/6 1915

20 UNDERTAKER W. B. Bedford ADDRESS 117 T. Olive, Jeff. City Mo.

N. B.—Every item of information should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified.

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 "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH

County *Coll*

Township

Village

City

Registration District No. *213*

File No.

Primary Registration District No. *3014*

Registered No. *146*

(No. *1118 E. High* St. Ward)

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

2 FULL NAME

Akua Nelenia St Brice

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *W*
(Write the word)

16 DATE OF DEATH

Sept 1 191*5*
(Month) (Day) (Year)

6 DATE OF BIRTH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

Satisfactory Information Supplied 191*5* to 191*5*

that I last saw him *Satisfactory Information Supplied* 191*5*

and that death occurred, on the date stated, at *1118 E. High* m.

The CAUSE OF DEATH was as follows:

Heart failure in comd

apoplexy

Sudden Duration *64* yrs. mos. ds.

CONTRIBUTORY

(Secondary) (Duration) yrs. mos. ds.

(Signed) *C. G. Peller* M. D.

Sept 1, 1915 (Address)

*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

DATE OF BURIAL

191*5*

20 UNDERTAKER

ADDRESS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed *Sept 1* 191*5*

Registrar *M. B. Reed*

Original file, date *SEP* 1915, 19

All information called for must be written on this Supplementary Certificate.

N. S. Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Satisfactory Information Supplied

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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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), *29ds.*; *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.)

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