

N. B.—Every item of information should be carefully supplied. AGE 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.

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

**1 PLACE OF DEATH**

County .....  
Township .....  
or  
Village .....  
or  
City St Louis mo (NO. 1914 Angelica Ln St. 1 Ward)

Registration District No. 781 File No. 3809  
Primary Registration District No. 1003 Registered No. 433

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

**2 FULL NAME** Mm Sporenemann

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDWED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH April 14 1858  
(Month) (Day) (Year)

7 AGE 57 yrs. 8 mos. 21 ds. If LESS than 1 day.....hrs. or.....min.?

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

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

PARENTS	10 NAME OF FATHER <u>Jdy Sporenemann</u>
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>
	12 MAIDEN NAME OF MOTHER <u>Don't know</u>
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mm Sporenemann  
(Address) 1914 Angelica Ln

15 Filed JAN 10 1915 1915 Mau S Starkloff  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Jan. 7 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec. 28 1915 to Jan. 7 1916, that I last saw him alive on Jan. 7 1916, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia

CONTRIBUTORY (Secondary) Influenza  
Duration..... yrs..... mos. 6 ds.  
Duration..... yrs..... mos. 10 ds.  
(Signed) R. G. Woods M. D.  
1/8 1916 (Address) 1105 Palisades

\*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 New Berlin DATE OF BURIAL Jan 10 1916

20 UNDERTAKER Biedermann, Dunkman ADDRESS 1937 St Louis Ave

U.S. GOVERNMENT PRINTING OFFICE: 1917

# 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 organ; "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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE 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.

PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_ or Village \_\_\_\_\_ or City St. Louis Mo (NO. 1914 Angelica Str. St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 791 File No. 3809

Primary Registration District No. 1003 Registered No. 433

FULL NAME Frederick William Kossmann

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>April 14</u> , 18 <u>58</u> (Month) (Day) (Year)		
AGE <u>57</u> yrs. <u>8</u> mos. <u>21</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>Bricklayer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Germany</u>		
PARENTS	NAME OF FATHER <u>H. Kossmann</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>	
	MAIDEN NAME OF MOTHER <u>Don't know</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Germany</u>	

DATE OF DEATH Jan. 7, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 28, 1915, to Jan. 7, 1916, that I last saw him alive on Jan. 7, 1916, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:  
Lobar Pneumonia

Contributory Influenza  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 6 ds.

(Signed) W. E. Wobus M. D.  
1/8, 1916 (Address) 1105 Salisbury

\*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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wm. H. Kossmann  
(ADDRESS) 1914 Angelica Str.

PLACE OF BURIAL OR REMOVAL <u>New Bethlehem</u>	DATE OF BURIAL <u>Jan 10</u> , 191 <u>6</u>
UNDERTAKER <u>Beiderwieden &amp; Neubauer</u>	ADDRESS <u>434 E. Louis Ave</u>

Filed MAY 23 1916 1916 Max Starkloff REGISTRAR

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