

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

PLACE OF DEATH

County Bron
Township Acacia
or
Village Pilot Knob
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 392
Primary Registration District No. 4231

File No. 17763
Registered No. 3740

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

FULL NAME Friedrich Anton Ebrecht

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED married
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH August 14, 1851
(Month) (Day) (Year)

AGE 64 yrs. 9 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ mln.?

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

BIRTHPLACE (City or town, State or foreign country) Fredricks town Mo

NAME OF FATHER Fredrick Ebrecht

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

MAIDEN NAME OF MOTHER Catherine Heisinger

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs F. A. Ebrecht.

(ADDRESS) Pilot Knob Mo

Filed May 20, 1916, Lizzie J Effinger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 18, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 14, 1916, to May 18, 1916, that I last saw her alive on May 16th, 1916, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
82 H

(Duration) ___ yrs. ___ mos. 2 ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G. W. Farrar M. D.
May 20, 1916 (Address) Fronton 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 Middlebrook Cemetery DATE OF BURIAL May 19, 1916.

UNDERTAKER Abie & Son ADDRESS Fronton, 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.)

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 Iron
Township Pilot Knob
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 392 File No. _____
Primary Registration District No. 4231 Registered No. 10

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

2 FULL NAME Fredrick Anton Ebrecht

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH 5/18/1916
(Month) (Day) (Year)

6 DATE OF BIRTH _____ (Month) _____ (Day) 1 _____ (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

7 AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(Duration) _____ yrs. _____ mos. 2 ds.

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

CONTRIBUTORY Under a broken blood vessel (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

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

PARENTS
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) _____

(Signed) Low Taylor M.D. 5/20/1916 (Address) Fronton, Mo.

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

15 Filed July 11, 1916 Lizzie J. Effinger Registrar

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

Satisfactory Information Supplied

Satisfactory Information

Address Supplied

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Revised United States Standard Certificate of Death

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

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