

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 *Cooper*

Township *Pilot Grove*

Village *Pilot Grove*

City *Pilot Grove*

Registration District No. *222*

Primary Registration District No. *5303*

File No. *23995*

Registered No. *9*

2 FULL NAME *Juliana Katharine Kraus*

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

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 *Nov 2 1858* (Month) (Day) (Year)

7 AGE *57* yrs. *8* mos. *2* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *House Keeping* (b) General nature of industry, business, or establishment in which employed (or employer) *Farmers wife*

9 BIRTHPLACE (City or town, State or foreign country) *Cooper Co Mo*

10 NAME OF FATHER *Peter Woltman*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Forst Baden Germany*

12 MAIDEN NAME OF MOTHER *Anna P. Heilmann*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Fredericksburg Baden Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Frank X. Kraus* (Address) *Pilot Grove Mo.*

15 Filed *July 5 1916* T. O. Qualen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 4 1916* (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *June 28 1916* to *July 4 1916*, that I last saw him alive on *July 4 1916*, and that death occurred, on the date stated above, at *4.30 P.m.* The CAUSE OF DEATH\* was as follows:

*Septicæmia*

31 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *W. S. Barnes* M. D. (Address) *Pilot Grove 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 *Pilot Grove St Joseph* DATE OF BURIAL *July 6 1916*

20 UNDERTAKER *Elliott & Chapman* ADDRESS *Pilot Grove 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*, *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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum*, 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. Examples: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asiheria," "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.)

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.

WHILE PLAINLY, WITH NO INK—THIS IS A PERMANENT RECORD

# 1 PLACE OF DEATH

County Cooper  
Township Pilot Grove  
or  
Village  
or  
City

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

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

Registration District No. 222 File No.  
Primary Registration District No. 5303 Registered No. 9  
St. Ward

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

2 FULL NAME Juliane K. Kraus

### PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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)

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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 7/5 L. O. Quabton  
Filed Sept 4 - 1916 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4, 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from  
the date of death to the date of death, on the date stated above, at  
and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Septicemia  
(Caused by suppurative  
Phlebitis)  
(Duration) 20 yrs. 7 mos. 7 ds.

CONTRIBUTORY  
(Secondary)

(Signed) W. S. James M. D.  
7/4, 1916 (Address) Pilot Grove 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 20 yrs. 7 mos. 7 ds. In the  
State 20 yrs. 7 mos. 7 ds.

Where was disease contracted  
if not at place of death?

Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL Pilot Grove Mo. DATE OF BURIAL  
Sept 4 - 1916

20 UNDERTAKER Elliott & Chapman ADDRESS Pilot Grove

Original file, date JUL - 1916, 19.....

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

# 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, 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), 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.)