

ould state
important.

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

1 PLACE OF DEATH

County Buchanan
Township
or
Village
or
City St. Joseph (NO. 1326 No. 12th. St.: Ward)

Registration District No. 85 File No. 33609
Primary Registration District No. 1001 Registered No. 1037

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

2 FULL NAME Elizabeth Schmelebeck

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 MARRIED Married <small>(Write the word)</small>
6 DATE OF BIRTH December, 27, 1887 <small>(Month) (Day) (Year)</small>		
7 AGE 28 yrs. 10 mos. 7 ds.	If LESS than 1 day.....hrs. or.....min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work Household	1290	
(b) General nature of industry, business, or establishment in which employed (or employer) At Home	36	
9 BIRTHPLACE AUSTRIA Hungary		

3 MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from **Jan 20, 1916** to **Oct 4, 1916**, that I last saw her alive on **Oct 4, 1916**, and that death occurred, on the date stated above, at **4:00 P.M.**

The CAUSE OF DEATH* was as follows:
Septicemia following Laparotomy for pus tubes.

PARENTS	10 NAME OF FATHER Joseph Seibel
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Austria
	12 MAIDEN NAME OF MOTHER Susan Funk
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Austria

CONTRIBUTORY **none**
(Secondary)

(Duration) **8** yrs. **10** mos. **4** ds.

(Signed) **Justin F. Kane** M. D.
Oct 4, 1916 (Address) **572 Edmund**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Schmelebeck
(Address) 1326 No. 12th

*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 Oct 5, 1916 Dr. J. K. Beasly
Doc. Registrar

19 PLACE OF BURIAL OR REMOVAL **Mt. Olivet Cemetery** DATE OF BURIAL **Oct. 5, 1916**

20 UNDERTAKER **W.O. Sidunfader** ADDRESS **215 No. 10th**

N. B.—CAUTION

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, 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 Buchanan

Township

Registration District No. 85

File No.

Village

Primary Registration District No. 1001

Registered No. 1032

City

St. Joseph

(NO

St.

Ward

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

2 FULL NAME

Elizabeth Schmebeck

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

F W. M

6 DATE OF BIRTH

(Month) (Day) 1 (Year)

7 AGE

If LESS than 1 day.....hrs. or.....min.?

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

Filed

Dec. 4, 1916 Dooney

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 4 1916
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

the (Place) saw him..... alive on..... 191.....
and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Septicemia following Laparotomy for peritonitis
status post peritonitis
(Duration) yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

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

(Signed)

10-4-1916 (Address) 822 Edwondo

*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.....

20 UNDERTAKER

ADDRESS

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

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

N. E. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state hospital or institution, give its NAME instead of street and number. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY INFORMATION

Revised United States Standard Certificate of Death

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

60924

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