

PLACE OF DEATH

County WarrenTownship Elkhorn

Village _____

City _____ (NO. _____)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 88File No. 36613Primary Registration District No. 171Registered No. 33

St. _____ Ward _____

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

FULL NAME Henry Frederick Karrenbrock

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE W SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(If write the word)DATE OF BIRTH: May 3rd, 1904
(Month) (Day) (Year)AGE 12 yrs. 5 mos. 9 ds. If LESS than
1 day, _____ hrs. or _____ min.?OCCUPATION
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____BIRTHPLACE
(City or town, State or foreign country) MissouriPARENTS
NAME OF FATHER William Karrenbrock
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
MAIDEN NAME OF MOTHER Edizabith Pollier
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Karrenbrock Jr. Pr.(ADDRESS) Wright City, Mo.Filed Oct 14, 1916 W. H. Morse
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October 12, 1916
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Oct 12th, 1916, to Oct 12th, 1916, that I last saw him alive on Oct 12th, 1916, and that death occurred, on the date stated above, at 7 m.The CAUSE OF DEATH* was as follows:
Accident - Dies from Horns of age 194B
103B (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) John A. Dyer M. D.
Oct 14, 1916 (Address) Wright City, 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 Stone Church Cem DATE OF BURIAL Oct 14th, 1916UNDERTAKER F W Nieling ADDRESS Warrenton Mo.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....(NO.....)

Registration District No.

Primary Registration District No.

File No.

Registered No.

St. Ward)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
	DATE OF BIRTH	

..... (Month), 191..... (Day), 191..... (Year)

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

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE
(City or town, State or foreign country)

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

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

(ADDRESS)

Filed, 191..... REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH, 191..... (Month), 191..... (Day), 191..... (Year)

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

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

Contributory
(SECONDARY), 191..... (Address)

(Signed), 191..... (Address)

M. D.

* 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. State yrs. mos. ds.

Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, 191.....
UNDERTAKER

ADDRESS

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

1 PLACE OF DEATH
County *Washington*
Township *Albion*
Village
City

Registration District No. *6171* File No. *33*
Primary Registration District No. Registered No.
(NO. St. Ward)

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

2 FULL NAME *Henry J. Kamubner*

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE yrs. mos. ds. 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)

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)

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

15 Filed *Oct 14 1916* *W.H. Moore* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 12 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191 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:
Accident Arid from Hæmorrhage + Necrosis of lower part of leg caused by Mr. falling out

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. Signed *John A. Dyer* M.D. *Oct 14 1916* (Address) *Wornton*

*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

Supplementary Certificate
Satisfactory Information Supplied
Satisfactory Information Supplied
Satisfactory Information Supplied

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), *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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