

PLACE OF DEATH

County Gasconade
Wardship Third CreekMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 491 File No. 29 37312
Primary Registration District No. 5419 Registered No. 29

Age _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Bergen Danuser

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)DATE OF DEATH November 3, 1916
(Month) (Day) (Year)DATE OF BIRTH Aug 6, 1841
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from May 16, 1916, to Nov. 3, 1916, that I last saw her alive on Nov. 3, 1916, and that death occurred, on the date stated above, at 1:30 p. m.AGE 76 yrs. 2 mos. 27 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work General house work
(b) General nature of industry, business, or establishment in which employed (or employer) 166th of the KidneyDiabetes following Traumatism of the Kidney.BIRTHPLACE (City or town, State or foreign country) Switzerland 103A(Duration) 2 yrs. _____ mos. _____ ds.NAME OF FATHER Hans SutterContributory Contracting cold
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.BIRTHPLACE OF FATHER (City or town, State or foreign country) Switzerland(Signed) J. W. Burgess M. D. Nov. 3, 1916 (Address) Bell Mo.MAIDEN NAME OF MOTHER Bergen Benhart

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death?

(Informant) John Danuser
(ADDRESS) Bland. Mo

Former or usual residence.

PLACE OF BURIAL OR REMOVAL Woollem Cemetery DATE OF BURIAL Nov. 5, 1916UNDERTAKER V. C. Strahman ADDRESS Woollem Mo.Filed Nov 3, 1916 C. H. Buddemer REGISTRAR

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, 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), *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.)

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

1 PLACE OF DEATH

County *Lascomade*
Wards *Third Creek*

Registration District No. *991* File No. _____

Primary Registration District No. *5419* Registered No. *29*

(NO. _____ St. _____ Ward _____)

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

2 FULL NAME

Berger Danuser

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 *Nov - 3* 191*6*
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him *and satisfactory information supplied* alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* was as follows:

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

Death following trauma of the kidney Feb 1915. ab fell and bruised kidney
(Duration) *2* yrs. _____ mos. _____ ds.

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

CONTRIBUTORY (Secondary) *Contracting Cold*
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. H. Burgess* M. D.
11/3, 191*6* (Address) *Beale Mo.*

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) _____

*State the Disease Causing Death, or, in death 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 _____

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

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

15 Filed *11/3* 191*6* *H. Budden* Registrar

UNDERTAKER _____ ADDRESS _____

Original file, date. *Nov 3 1916* 19____

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, 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), *20ds.*; *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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