

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

PLACE OF DEATH

County Saline

Township Liberty

Village \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. 801

File No. 39625

Primary Registration District No. 6045

Registered No. \_\_\_\_\_

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

FULL NAME Raymond G. Zumbke

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)

DATE OF BIRTH Nov-20-1916  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 13 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

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

BIRTHPLACE Saline Co. Mo.  
(City or town, State or foreign country)

NAME OF FATHER George Zumbke

BIRTHPLACE OF FATHER St. Charles Mo.  
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER Ida Suden

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

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) George Zumbke  
(ADDRESS) Swift Springs Mo.

Filed Nov. 20, 1916

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov-23-1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased at birth, 1916,  
that I last saw him alive on Nov-20, 1916,  
and that death occurred, on the date stated above, at 1 A. M.

The CAUSE OF DEATH\* was as follows:  
Dilation Ventricular Septum  
Congenital  
1570 (Duration) 150 yrs. \_\_\_\_\_ mos. 27 ds.

Contributory X  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. H. Jarvis M. D.  
11/23-1916 (Address) Swift Springs 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 Liberty - Herman Church DATE OF BURIAL Nov 24, 1916

UNDERTAKER A. F. Riggell ADDRESS Swift Springs 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, 8 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 Saline  
Township Liberty  
Village  
City

Registration District No. 801 File No.  
Primary Registration District No. 6045 Registered No.

(NO. St. Ward)

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

2 FULL NAME

Raymond G. Zumbuhl

PERSONAL AND STATISTICAL PARTICULARS

SEX M 4 COLOR OR RACE W. 5 SINGLE  MARRIED  WIDOWED  OR DIVORCED   
DATE OF BIRTH 12/17/1888  
OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, occupation, or establishment in which employed (or employer)  
PLACE OF BIRTH  
10 NAME OF FATHER  
11 BIRTHPLACE OF FATHER  
12 MAIDEN NAME OF MOTHER  
13 BIRTHPLACE OF MOTHER

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 23 1916  
I HEREBY CERTIFY, that I attended deceased from 17 to 1916  
that I last saw him alive on 1916  
and that death occurred, on the date stated above, at 1916  
The CAUSE OF DEATH\* was as follows:

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
THE Deceased  
(Address)  
Filed Dec 1 1916 J. S. Harrison  
Registrar

CONTRIBUTORY  
(Signed) 1916 (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 5 yrs. 0 mos. 0 ds. In the State 5 yrs. 0 mos. 0 ds.  
Where was disease contracted if not at place of death?  
Former or usual residence 1916

19 PLACE OF BURIAL OR REMOVAL 1916 DATE OF BURIAL  
20 UNDERTAKER 1916 ADDRESS

Original file, date NOV 1916, 19

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

SUPPLEMENTARY CERTIFICATE  
Satisfactory Information Supplied.

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