

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE 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 **41913**

PLACE OF DEATH

County Morgan
Township Habo Creek
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 919 File No. _____

Primary Registration District No. 5793a Registered No. 26

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

FULL NAME Anna Gattermeyer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widow</u> (Write the word)
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DATE OF BIRTH March 29, 1880
(Month) (Day) (Year)

AGE 86 yrs. 8 mos. 26 ds.
If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Austria

NAME OF FATHER Martin Winkler

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

MAIDEN NAME OF MOTHER Adel Kuntz

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos Gattermeyer
(ADDRESS) Plain Mo

Filed Dec 27, 1916 S. M. Newton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 25, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 1, 1916, to Nov 15, 1916, that I last saw her alive on Nov 15, 1916, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Ulcers of Both legs
153B

(Duration) 20 yrs. 4 mos. 4 ds.

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mo. _____ ds.
(Signed) Chas J West M. D.
Dec 26, 1916 (Address) Stover 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 Stover Mo near
Thomas Cem near

DATE OF BURIAL Dec 27, 1916

UNDERTAKER E R Kapp
ADDRESS Stover 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*, *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*, *Sar-*

coma, 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.)



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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 *Wayne*
Township *Wayne Creek*
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. *919* File No. _____
Primary Registration District No. *5793A* Registered No. *26*

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

2 FULL NAME *Anna Gattermayer*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *March 29 1830*
(Month) (Day) (Year)

7 AGE *86 yrs 8 mos 26 ds*
If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country) *Austria*

PARENTS
10 NAME OF FATHER *W. K. Kunder*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Austria*
12 MAIDEN NAME OF MOTHER *St. John*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Austria*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs Louis Ebeling*
(Address) *Stover Mo*

15. Filed *Dec 27 1916*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 25 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____ 1916 to _____ 1917
that I last saw him alive on _____ 1917
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Ulcers of Both leg
14 30
(Duration) (yrs) (mos) (ds)

CONTRIBUTORY (Secondary)
(Duration) (yrs) (mos) (ds)
(Signed) *Chas West* M. D.
Dec 26 1916 (Address) *Stover 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 *Yert Cem* 407
20 DATE OF BURIAL *Dec 27 1916*

20 UNDERTAKER *OK Rapp* ADDRESS *Stover Mo*

Revised United States Standard Certificate of Death

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

41913

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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.)