

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

PLACE OF DEATH

County Cape Girardeau
Township " do "
Village _____
or
City Cape Girardeau (NO. _____) St.: _____ Ward _____

Registration District No. 120

File No. 4957

Primary Registration District No. 2178

Registered No. 1032

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

FULL NAME Fritz Kasten

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 7, 1901
(Month) (Day) (Year)

AGE 16 yrs 7 mos 5 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Shannectown Mo

NAME OF FATHER Henry Kasten

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

MAIDEN NAME OF MOTHER Mary Boren

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Kasten
(ADDRESS) Shannectown Mo.

Filed Feb. 13th 1917 R. W. Frissell

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 13th 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 11th 1917, to Feb. 12th 1917, that I last saw him alive on Feb. 12th 1917, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Fracture of occipital bone and at base of skull. accidental injury.

(Duration) 2 1/2 yrs. mos. ds.

Contributory (SECONDARY) 2 1/2 yrs. mos. ds.

(Signed) E. H. Schultz M. D.
Feb. 13th 1917 (Address) Cape Girardeau, 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 Shannectown Mo DATE OF BURIAL Feb. 14 1917

UNDERTAKER Waltham F. & U. Co Cape Girardeau Mo. ADDRESS _____

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____)

Registration District No. _____

Primary Registration District No. _____

Registered No. _____

File No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____
 (If wife the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (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) _____ (Day) _____ (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:

_____, 191_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Signed) _____, 191_____ (Address) _____ yrs. _____ mos. _____ ds. 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. 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 _____

DATE OF BURIAL _____, 191_____

UNDERTAKER _____

ADDRESS _____

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 Cape Girardeau
 Township "
 Village "
 City " (NO. _____ St. _____ Ward _____)

Registration District No. 125 File No. _____
 Primary Registration District No. 5178 Registered No. 1532

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

2 FULL NAME Fritz Kasten

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____ 1 _____ 191____
 (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) _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7/13 1917
 (Month) (Day) (Year)

17 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:
fracture of occipital bone and lat base of skull
accidental injury
170 (Duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY thrown from horse
 (Secondary) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) E. Schult M. D.
7/13 1917 (Address) Cape Girardeau

*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 _____

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

20 UNDERTAKER _____ ADDRESS _____

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

15 Filed 7/13 1917 R. W. Frissell
 Registrar

SUPPLEMENTARY INFORMATION STATE BOARD OF HEALTH

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*; *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 inter-current) 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 septichaemia," "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.)

1964