

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

1 PLACE OF DEATH

County Green

Township .....

or

Village .....

or

City Springfield (NO. 830 Hovey ave St. .... Ward)

Registration District No. 318

File No. 8561

Primary Registration District No. 2001

Registered No. 159

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

2 FULL NAME Lottie Abbott Schurer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE  
MARRIED  
WIDOWED  
OF DIVORCED  
(Write the word)

Divorced

6 DATE OF BIRTH

Aug 6 1880  
(Month) (Day) (Year)

7 AGE

36 yrs. 7 mos. 12 ds.

If LESS than  
1 day..... hrs.  
or..... min.?

8 OCCUPATION

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

house work

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

9 BIRTHPLACE

(City or town, State or foreign country)

Kan.

10 NAME OF FATHER

George Schurer

11 BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ill

12 MAIDEN NAME OF MOTHER

Lena Wintzy

13 BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ill

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Schurer

(Address) 830 Hovey ave

15 MAR 19 1918

Filed

191

Geo. J. Jones

Registrar

2) MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 18 1918  
(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:

Stomach Trouble

+ Paralysis

817

87 E (Duration) 10 yrs. .... mos. .... ds.

CONTRIBUTORY

(Secondary)

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

(Signed)

Ch. Parson Cover

3-17-1918 (Address) Springfield 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

East Lawn

DATE OF BURIAL

Mar 20 1918

20 UNDERTAKER

W. Klugger & Co

ADDRESS

SPRINGFIELD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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, 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 child-birth 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.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE 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

1 PLACE OF DEATH

County *Greene*

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

Township \_\_\_\_\_

Registration District No. *318*

File No. \_\_\_\_\_

Village \_\_\_\_\_

Primary Registration District No. *2001*

Registered No. *1571*

City *Springfield*

(NO. *830 Hardy St.*)

Ward \_\_\_\_\_

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

2 FULL NAME *Lottie Abbott Schrum*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *Mar 18 1918*  
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ 191\_\_\_\_\_ to \_\_\_\_\_ 191\_\_\_\_\_  
that I have seen \_\_\_\_\_ 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\* is as follows:

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

*near trouble & paralysis  
Acute asphyxia*  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9 BIRTHPLACE  
(City or town, State or foreign country) \_\_\_\_\_

CONTRIBUTORY (Secondary) \_\_\_\_\_  
Duration \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

(Signed) *Ch. Pappas, M.D.*  
*Greene, Mo.* (Address) *Springfield, Mo.*

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Informant) \_\_\_\_\_

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Address) \_\_\_\_\_

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

15 \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ OF BURIAL \_\_\_\_\_ 191\_\_\_\_\_

Filed *Greene* 191\_\_\_\_\_ Registrar *Chas F. Jahn*

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Original file, date \_\_\_\_\_, 19\_\_\_\_\_

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

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

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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.)

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