

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 10163

1 PLACE OF DEATH

County Polk

Township _____

or _____

Village Humansville

or _____

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 703

File No. _____

Primary Registration District No. 4424

Registered No. 7

2 FULL NAME Jessie L. Bremer

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE MARRIED WIDOWED OR DIVORCED Widow
(Write the word)

16 DATE OF DEATH 2 Mich 81 1918
(Month) (Day) (Year)

6 DATE OF BIRTH Sept 15 89
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mich 25 1918 to Mich 31 1918
that I last saw her alive on Mich 31 1918

7 AGE 26 yrs. 6 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?

and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

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

Peritonitis
1943
1375 (Duration) _____ yrs. _____ mos. 4 ds.

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

CONTRIBUTORY (Secondary) Hysterectomy
(Duration) _____ yrs. _____ mos. 6 ds.

10 NAME OF FATHER Edmon Walker

(Signed) Stuppleson M. D.
Mich 31 1918 (Address) Humansville Mo

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

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

12 MAIDEN NAME OF MOTHER Lula Long

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

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

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) Stuppleson

Former or usual residence _____

(Address) Humansville Mo

15 Filed Apr. 1 1918 M. C. Sellens Registrar

19 PLACE OF BURIAL OR REMOVAL Humansville mo DATE OF BURIAL Apr. 1 1918

20 UNDERTAKER L. G. Joseph ADDRESS Humansville, mo.

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, 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), *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.)

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.

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

1 PLACE OF DEATH

County Polk Registration District No. 703 File No. _____
 or _____
 Village Hannasville Primary Registration District No. 4474 Registered No. 7
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

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

2 FULL NAME Jessie L. Primer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4 COLOR OR RACE <u>B</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>W</u> (Write the word)
6 DATE OF BIRTH _____ (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 Satisfactory Information Supplied	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 March 31, 1918
(Month) _____ (Day) _____ (Year) _____

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

The CAUSE OF DEATH* was as follows:
Septicemia
Peritonitis
Granuloma

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

CONTRIBUTORY Hysterectomy
(Secondary)

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

(Signed) Pluffebauer M. D.
March 31, 1918 (Address) Hannasville 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 _____ DATE OF BURIAL _____, 191____

20 UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied

SUPPLY MISSING INFORMATION

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

15 Filed Apr 1, 1918 E. M. L. Sallas
 Registrar

Revised United States Standard Certificate of Death

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