

## 1 PLACE OF DEATH

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 12273

County Rushman

Township.....

Registration District No. 85File No. 120

Village.....

Primary Registration District No. 1001Registered No. 564City St. Joseph(NO. Noyes Hosp St. Ward)

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

2 FULL NAME Zemiss Weese

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 MARRIED Married  
UNMARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)6 DATE OF BIRTH Dec 15 1833  
(Month) (Day) (Year)7 AGE 85 yrs. 0 mos. 0 ds. -If LESS than 1 day... hrs. or... min.?8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Retired9 BIRTHPLACE (City or town, State or foreign country) Unknown10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) W B Weese  
(Address) Boston Iowa15 File Apr 26 1918 H. J. L. Smith Registrar  
Deputy

## 3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4/22 1918  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from 4/17 1918 to 4/22 1918  
that I last saw her alive on..... 1918  
and that death occurred, on the date stated above, at 12 P m.The CAUSE OF DEATH\* was as follows:  
191 Nephritis  
131 2 years  
130  
(Duration) 2 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Prostatectomy  
(Duration) 1 yrs. 0 mos. 0 ds.  
(Signed) H. J. L. Smith M. D.  
Apr 23 1918 (Address) St. Joseph 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. 7 ds. In the State 50 yrs..... mos. 7 ds.  
Where was disease contracted -  
is not at place of death?  
Former or usual residence Blockton, Ia19 PLACE OF BURIAL OR REMOVAL Blockton Iowa DATE OF BURIAL Apr 24 191820 UNDERTAKER William - M. Hill ADDRESS 1708 Mcanis

# 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.)

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

1 PLACE OF DEATH

County .....

Township .....

or

Village .....

or

City .....

Registration District No. 85

File No. ....

Primary Registration District No. 1001

Registered No. 564

St. .... Ward)

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

2 FULL NAME

Joseph Myra Kiepe  
Genevieve Weese

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH ..... 1 ..... Year  
(Month) (Day)

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) .....

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

15 Filed Apr 22 1918 J.H.D. Lamater Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4-22-8  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... to ..... 191..... that I last saw him alive on ..... 191..... and that death occurred on the date stated above, ..... m. The CAUSE OF DEATH\* was as follows:

Acute nephritis  
119  
(Duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Prosthetic  
(Duration) ..... yrs. .... mos. .... ds. (Signed) A. Storgrove M. D. Apr 23, 1918 (Address) Barlett Blas

\*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  
Satisfactory Information Supplied  
Satisfactory Information Supplied  
Satisfactory Information Supplied

CAUSE OF DEATH PLAINLY STATED. OCCUPATION IS VERY IMPORTANT. STATE OCCUPATION PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

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2788  
—  
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