

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

1 PLACE OF DEATH

County St Charles

Township _____

or _____

Village _____

or _____

City St Charles

Registration District No. 757

File No. 14414

Primary Registration District No. 3036

Registered No. 47

(NO. 1228 North 5th St.; _____ Ward)

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

2 FULL NAME Carolina Wessler

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH March 4, 1881
(Month) (Day) (Year)

7 AGE 87 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. or min.?

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

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

10 NAME OF FATHER Winkelmeier

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

12 MAIDEN NAME OF MOTHER Anna Duma

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. H. Wessler (Address) St Charles Mo.

15 Filed Apr. 6th, 1918 Chas. W. Koarsting Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 5th, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 3^d, 1918, to April 5th, 1918, that I last saw her alive on April 5th, 1918, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:
Injuries sustained by falling down a stairway fracture of right 4th rib side and internal injuries
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Senility + Shock
(Secondary) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) B. P. Weather M. D.
4-5-1918 (Address) St. Charles

*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 St Peter Cemetery DATE OF BURIAL April 7, 1918

20 UNDERTAKER W. H. Hallmyer ADDRESS St Charles 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, 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 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.)

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CERTIFICATE OF DEATH**

1 PLACE OF DEATH
County St. Charles
Township.....
or
Village St. Charles
or
City..... (NO. St. Ward)

Registration District No. 757 File No.
Primary Registration District No. 3036 Registered No. 47

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

2 FULL NAME Carolina Weesler

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 1 (Year)
Satisfactory Information Supplied.

7 AGE 15 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..... 191..... Registrar.....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr - 5, 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:
Injuries sustained by falling down a stairway. Fracture of rib 4th right side and internal injuries. Accidental Vertigo
Duration..... yrs..... mos..... ds.

CONTRIBUTORY Vertigo
(Secondary) (Duration)..... yrs..... mos..... ds.
(Signed) B. P. Woulter M. D.
7-11, 1918 (Address) St. Charles, Mo.

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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.

Revised United States Standard Certificate of Death

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

1494

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