

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

1 PLACE OF DEATH

County Stone  
Township Pauca de Lou  
or  
Village  
or  
City (NO ..... St.; ..... Ward)

Registration District No. SHK File No. 15868  
Primary Registration District No. 6470 Registered No. 2

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

2 FULL NAME Urel Magers

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH April 17 1918  
(Month) (Day) (Year)

6 DATE OF BIRTH Oct 20 1911  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 16, 1918, to April 17, 1918, that I last saw her alive on April 17, 1918, and that death occurred, on the date stated above, at 11 P. m.

7 AGE 6 yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH\* was as follows:

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

Meningitis  
79 B  
(Duration) yrs. mos. 2 ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.  
(Signed) J. K. Wade M. D.  
4/17, 1918 (Address) Pauca de Lou

PARENTS  
10 NAME OF FATHER James S Magers  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) mo  
12 MAIDEN NAME OF MOTHER Maud B Seibles  
13 BIRTHPLACE OF MOTHER (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.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) James S Magers  
(Address) Pauca de Lou

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

At place of death 6 yrs. 6 mos. 27 ds. In the State 6 yrs. 6 mos. 27 ds.  
Where was disease contracted if not at place of death?  
Former or usual residence

15 Filed April 18, 1918 J. K. Wade Registrar

19 PLACE OF BURIAL OR REMOVAL Pauca de Lou Cemetery DATE OF BURIAL April 18, 1918  
20 UNDERTAKER Reeds Merchants Co ADDRESS Clark St

# 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.)

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CERTIFICATE OF DEATH**

1 PLACE OF DEATH

County St. Louis Registration District No. 544 File No. \_\_\_\_\_  
 Township Pance de Leon or \_\_\_\_\_ Primary Registration District No. 6170 Registered No. 2  
 Village \_\_\_\_\_ or \_\_\_\_\_ City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME Chel Wagner

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3 SEX ♀ 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) W  
 6 DATE OF BIRTH Oct 20 1911 (Month) (Day) (Year)  
 7 AGE 6 yrs 5 mos 27 ds If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
 8 OCCUPATION (a) Trade, profession, or particular kind of work School Girl (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

16 DATE OF DEATH Apr 17 1918 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, that I attended deceased from April 16 1918 to April 17 1918 that I last saw him alive on April 17 1918 and that death occurred on the date stated above, age 11/8 m.

The CAUSE OF DEATH was as follows:  
Cerebral Pneumonia  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 da.

9 BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_  
 10 NAME OF FATHER James S Wagner  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
 12 MAIDEN NAME OF MOTHER Maud B Seidler  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 (Signed) \_\_\_\_\_ M. D.  
 \_\_\_\_\_, 191 \_\_\_\_\_ (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) James S Wagner (Address) Pance de Leon

\*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 6 yrs 5 mos 27 ds In the State 6 yrs 5 mos 27 ds  
 Where was disease contracted if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

15 Filed April 18 1918 J. H. Madel Registrar

19 PLACE OF BURIAL OR REMOVAL Pance de Leon DATE OF BURIAL April 18 1918  
 20 UNDERTAKER Reed's Mercantile Co ADDRESS Osark Mo

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"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.)

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