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

1 PLACE OF DEATH

County Buchanan

Township ..... Registration District No. 85 File No. 16270 113

or

Village ..... Primary Registration District No. 1001 Registered No. 729

or

City St. Joseph (NO. 409 So 17th St.; ..... Ward).

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

2 FULL NAME Anna M Hers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE M

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Oct 12th (Month) (Day), 1839 (Year)

7 AGE 78 yrs. 7 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER Not Known Heinz

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

12 MAIDEN NAME OF MOTHER Not Known Moucke

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gus Hers

(Address) 409 So 17

15

Filed ....., 191...., ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31 (Month) (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 2, 1918, to May 31, 1918, that I last saw her alive on May 30, 1918, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Nephritis - chronic parenchymatous

131

(Duration) about 2 yrs. 150 mos. — ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) L C Bauman M. D.

6/1, 1918 (Address) c/o Lincoln Bldg St Joseph

*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 46 yrs. ..... mos. ..... ds. In the State 46 yrs. ..... mos. ..... ds.

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

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Mt Moria

DATE OF BURIAL 6/31, 1918

20 UNDERTAKER St Joseph Und Co

ADDRESS 105 No 9th

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 *septichaemia*," "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 Buch — Registration District No. 85 — File No. .....

Township ..... — Primary Registration District No. 1001 — Registered No. 729

City St Joseph (No. ....., ... St. ..... Ward)

2. FULL NAME Anna M. Hirs

(a) Residence. No. 409.40.17 St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F — 4. COLOR OR RACE W — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED June 3 1918 H D Lamaster M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1918

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occured, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

Sanitary Information Supplied

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States Standard Certificate of Death

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

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NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death; Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.