

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

47731-1
25

1 PLACE OF DEATH
County Madaway
Township Jefferson
or
Village
or
City

Registration District No. 620
Primary Registration District No. 4371

File No. _____
Registered No. _____

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

2 FULL NAME Dr. Joseph W. Untert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) single

6 DATE OF BIRTH 9 4 900
(Month) (Day) (Year)

7 AGE 18 yrs. 3 mos. 17 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) Clyde

PARENTS
10 NAME OF FATHER Wm Untert
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
12 MAIDEN NAME OF MOTHER Kathleen Fallman
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Madaway Co. Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mr. Wm Untert (Address) Clyde Mo

15 Filed Feb. 28, 1919 Dr. P. F. Farrell Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-24 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 15 1918, to Dec 20 1918, that I last saw him alive on 12-20 1918, and that death occurred, on the date stated above, at 10:30 a.m. The CAUSE OF DEATH* was as follows:

Pneumonia
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) _____
(Duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza
(Duration) _____ yrs. _____ mos. 15 ds.

(Signed) D. J. Hunter M. D.
12/24/1918 (Address) Rainwood 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 18 yrs. _____ mos. _____ ds. In the State 18 yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Conception Mo DATE OF BURIAL 12-22-1918

20 UNDERTAKER Ch. E. Foster ADDRESS Conception 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, 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 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 Jefferson Registration District No. 620 File No. _____
 Township Jefferson Primary Registration District No. 437 Registered No. 25
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Frank Joseph Untite

(a) Residence No. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.
18 3 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed, (or employer) General Repair work
 (c) Name of employer Public Electric

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

10. NAME OF FATHER Wm Untite

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

12. MAIDEN NAME OF MOTHER Kate Kottmann

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

14. INFORMANT (Address) Wm Untite
Clyde Mo

15. FILED 12/22 1918 Dr. R.F. Farrell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 21 1918

17. I HEREBY CERTIFY: That I attended deceased from 12 to 12-21 1918
 that I last saw him alive on 12-20 1918 and that death occurred, on the date stated above, at 10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza

CONTRIBUTORY (SECONDARY) Bronchio-pneumonia (duration) yrs. mos. 10 da.
Bronchio-pneumonia (duration) yrs. mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH...
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination
 (Signed) W. H. Hunter M. D.
 (Address) Pharmaceutical Mo

*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 Conception Mo DATE OF BURIAL 12-22 1918

20. UNDERTAKER Dr. Proctor ADDRESS Conception, Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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Revised United States Standard Certificate of Death

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

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1-13-11
"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. Neyer report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

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.