WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should st
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa

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

1 PLACE OF DEATH

County Jefferson

Township Rock
or
Village
or
City (NO. St.: Ward)

Registration District No. 423 File No. 14345

Primary Registration District No. 5578 Registered No. 75

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

2 FULL NAME John Ott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

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

6 DATE OF BIRTH Aug (Month) 28 (Day) 1841 (Year)

7 AGE 77 yrs. 7 mos. 24 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)

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

PARENTS

10 NAME OF FATHER Franz J. Ott

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

12 MAIDEN NAME OF MOTHER Rosa Schauermann

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aloys Ott

(Address) Kimmswick Mo R F D

15 Filed 4-26 1919 W J F Kirk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 24 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 20 1919, to Apr 24 1919

that I last saw him alive on Apr 24 1919

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Locomotor Ataxia

(Duration) 4 yrs. 2 mos. ds.

(Signed) Dr. G. W. Leving M. D.

April 26 1919 (Address) Kimmswick 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. ....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 Immaculate Conception

DATE OF BURIAL April 26 1919

20 UNDERTAKER John E Koch

ADDRESS Fenton Mo

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATIST
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If de
hospital
give fu
of stre

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day

17 I HEREBY CERTIFY, that I attended d

....., 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, a

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... m

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... m

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violen
(1) Means of Injury; and (2) whether Accidental, Suicidal

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

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. .....

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BU

20 UNDERTAKER	ADDRESS

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.

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