

## PLACE OF DEATH

County Cape GirardeauTownship Shawnee

or

Village

or

City

Registration District No. 129Primary Registration District No. 5180

(NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

File No. 30845Registered No. 27

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

FULL NAME Wilhelmina Dralle

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Widowed</u>
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DATE OF BIRTH  
Oct. 8, 1853  
(Month) (Day) (Year)

AGE  
69 yrs. 94 mos. 24 ds.  
IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE  
(City or town, State or foreign country)  
Burfordville Mo

PARENTS	NAME OF FATHER <u>Gumbrecht</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>
	MAIDEN NAME OF MOTHER <u>Johanna D. M. Schuetz</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Adelphi Germany</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gustav A. Dralle(ADDRESS) Neelys Landing MoFiled Nov 3 1922 F. J. Schoser

REGISTRAR

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

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
November 2, 1922  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 9, 1921, to Nov 2, 1922, that I last saw her alive on Oct 22<sup>nd</sup>, 1922 and that death occurred, on the date stated above, at 9 a.m.  
The CAUSE OF DEATH\* was as follows:

Myelitis (Chronic)

(Duration) 2 yrs. 6 mos. \_\_\_ ds.

Contributory Fracturation of the spine

(Duration) 3 yrs. 6 mos. \_\_\_ ds.

(Signed) F. W. Grundmann M. D.

Nov 2, 1922 (Address) Jeff. out. Wash. St.

\*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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.

PLACE OF BURIAL OR REMOVAL

Miss Mo.

DATE OF BURIAL

Nov 5, 1922

UNDERTAKER

Neswell Turnb

ADDRESS

Jacques 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*, *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*, *peritonæum*, 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.)

Signature of Agent  
 Date of Death  
 Place of Death

THE CHIEF OF DEATH

Name of Deceased  
 Sex  
 Age  
 Date of Birth  
 Date of Death  
 Place of Death  
 Cause of Death  
 Contributory Cause  
 Name of Physician  
 Name of Undertaker  
 Name of Registrar  
 Name of Informant  
 Address of Informant  
 Signature of Registrar  
 Signature of Informant  
 Date of Report  
 Place of Report

ADDRESS

DATE OF BIRTH

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From History: Wilhelmina Dralle was grabbed by a horse, in her yard, and thrown backwards about 15 ft. Shortly afterwards symptoms of Myelitis developed, evidently due to above accident, and the cause of her death. (*Paraplegia*)

58845

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

**1. PLACE OF DEATH**

County Cape Girardeau Registration District No. 129 File No. ....  
 Township Shawnee Primary Registration District No. 5180 Registered No. 27  
 City ..... (No. ....) ..... St. .... Ward)

**2. FULL NAME** Wilhelmina Dealle

(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 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) .....

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 Nov 3 1922 F. J. Schorer REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 2 1922

17. I HEREBY CERTIFY That I attended deceased from Nov 9 to Nov 2, 1922 that I last saw him alive Nov 23, 1922 and that death occurred, on the date stated above.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Septicemia  
Was caused by a horse in front of her yard in her yard, and thrown  
15 ft. (duration) 2 yrs. 6 mos. da.  
could find spot.

CONTRIBUTORY (SECONDARY) .....  
 (duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, evidently in her yard

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) F. W. Granderson, M. D.

Nov 27 1922 (Address) 2349 North 1st St

\*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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

RECORD

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

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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 neoplasma); *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," "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: "Certificate 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.

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