

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

33971.9  
418

**1. PLACE OF DEATH**

County Warren Registration District No. 303 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4182 Registered No. \_\_\_\_\_  
 City Warrensburg (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward) \_\_\_\_\_

**2. FULL NAME** Annis Glass

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (If nonresident give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 44 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH** Dec 21 - 22

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 1922

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

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1922, to Dec 21, 1922 that I last saw her alive on Dec 21, 1922, and that death occurred, on the date stated above, at 11:30 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27th 1878  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
44 5 22

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Paralytic Stroke  
82h  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) Peace Valley (STATE OR COUNTRY) \_\_\_\_\_

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

10. NAME OF FATHER Franz Stein

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

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

20. WAS THERE AN AUTOPSY? \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Elizabeth Mueller

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Emil P. Hoffman, M. D.  
Dec 21, 1922 (Address) Warrensburg Mo

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

\*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.)

14. INFORMANT (Address) Eust Glass  
Warrensburg Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Catholic Cemetery DATE OF BURIAL Dec 24 1922

15. FILED Dec 22 1922 W.H. Dickson REGISTRAR

20. UNDERTAKER Carl E. Rudiger ADDRESS Warrensburg

# 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, meningis, 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," "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.

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

1. PLACE OF DEATH

County Gasconade Registration District No. 303 File No. ....  
Township ..... Primary Registration District No. 4182 Registered No. ....  
City Herman (No. ....) St. .... Ward)

2. FULL NAME

Bunie Glaser  
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 29, 1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>49</u>	<u>5</u>	<u>22</u>	

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 2029 1929 W.B. Dick  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21st 1928

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

1. PLACE OF DEATH  
 County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No.....)..... St..... Ward.....

2. FULL NAME  
 (a) Residence, No..... St..... Ward.....  
 (Usual place of abode).....  
 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  
 4. COLOR OR RACE  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

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 employee).....  
 (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)..... M. D.  
 15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH:..... DATE OF.....  
 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  
 20. UNDERTAKER ADDRESS

LOCAL REGISTRAR'S OFFICE