

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

70^a

1. PLACE OF DEATH

County Barry Registration District No. 31 File No. _____
 Township Fuddy Primary Registration District No. 4027 Registered No. 45
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Harold School

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF _____ (or) WIFE OF <u>George School</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>10 May 18</u>		
7. AGE YEARS <u>70</u>	MONTHS <u>1</u>	DAYS <u>14</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) <u>Broszkovo</u> <u>Poland</u>		
10. NAME OF FATHER <u>John B. Scholz</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		
12. MAIDEN NAME OF MOTHER <u>Germe Volkman</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-24 1933

17. I HEREBY CERTIFY That I attended deceased from Jan 20, 1933, to Jan 20, 1933, and that I last saw her alive on Jan 20, 1933, and that death occurred on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
931

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

CONTRIBUTORY (SECONDARY) GH
 (duration) _____ yrs. _____ mos. 4 ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) E. W. Hilleweg, M. D.
 , 19 (Address) Peine City 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.)

14. INFORMANT George School
 (Address) Peine City Mo.

15. FILED _____ 19 _____ REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Johns Cemetery DATE OF BURIAL 1/26 1933

20. UNDERTAKER W. Ballaway ADDRESS Monett

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 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 child-birth 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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Barry 31 State MISSOURI Registered No. _____
 Township Purdy 4022 or Village _____ or _____
 City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Karolin Schad
 (a) Residence. No. _____ St., _____ Ward _____
(Usual place of abode)
 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.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS **MEDICAL CERTIFICATE OF DEATH**

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

6 DATE OF DEATH (month, day, and year) Jan - 24 1923

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

7 I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____,

6 DATE OF BIRTH (month, day, and year) _____

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

7 AGE Years Months Days
(PLEASE indicate day, hrs or min.)

The CAUSE OF DEATH* was as follows:

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 _____

17 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

9 BIRTHPLACE (city or town) _____ (State or country) _____

18 Where was disease contracted _____ if not at place of death? _____

10 NAME OF FATHER _____

Did an operation precede death? _____ Date of _____

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____

Was there an autopsy? _____

12 MAIDEN NAME OF MOTHER _____

What test confirmed diagnosis? _____

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

(Signed) _____, M. D.
 _____, 19 (Address)

14 Informant _____ (Address) _____

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15 Filed May 10, 1923 A. J. Cleary (REGISTRAR)
 11-3184

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

See instructions on back of certificate.

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