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

1684

1. PLACE OF DEATH
County Lafayette — Registration District No. 466 — File No.
Township — Primary Registration District No. 4279 — Registered No. 2
City Wellington (No. ..... St. ..... Ward)

2. FULL NAME John Silmann
(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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr 27, 1850

7. AGE: Years 72 — Months 8 — Days 10 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Laborer
(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): Washington Mo

PARENTS
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: /
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): /

14. INFORMANT (Address): Otto Steiner

15. FILED Jan 8, 1923 F. W. Mann REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 7 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1923, to Jan 7, 1923, that I last saw him alive on Jan 7, 1923, and that death occurred, on the date stated above, at 12:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY (SECONDARY): Influenza
(duration) ..... yrs. ..... mos. 7 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) J. A. Mann, M. D
Jan 8, 1923 (Address) Wellington 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: Wellington Mo — DATE OF BURIAL: Jan 9 1923

20. UNDERTAKER: Ernest Fegert — ADDRESS: Lexington 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, 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: "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.

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4 ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

1 PLACE OF DEATH

County Lafayette

Township ____
or
Village ____
or
City Wellington (No. ____, ____ St.; ____ Ward)

466
4279

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of ____

Registered No. ____

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

2 FULL NAME John Selmann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): S

6 DATE OF BIRTH: April 27, 1850 (Month) (Day) (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 (State or country) ____

PARENTS

10 NAME OF FATHER ____

11 BIRTHPLACE OF FATHER (State or country) ____

12 MAIDEN NAME OF MOTHER X No Information X

13 BIRTHPLACE OF MOTHER (State or country) X No Information X

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(Address) ____

15 Filed Jan 8th, 1923 F. M. Mann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 7 (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 191____, to ____, 191____, that I last saw h____ alive on ____, 191____, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____, M. D.

____, 191____ (Address) ____

* 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 ____ DATE OF BURIAL ____, 191____

20 UNDERTAKER ____ ADDRESS ____

11—3184

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