

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



1733

1. PLACE OF DEATH

County Linn Registration District No. 491 File No. _____
 Township _____ Primary Registration District No. 4298 Registered No. 14
 City Froy (No. _____) St. _____ Ward _____

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 20 - 1841

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 81

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (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) Germany

10. NAME OF FATHER

Gus Schlegel

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

14. INFORMANT

(Address) Wm Schubert
Froy Mo.

15. FILED

1/25 19 23 W P Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 19 23

17. I HEREBY CERTIFY That I attended deceased from Jan 18 19 23 to Jan 22 19 23 that I last saw her alive on Jan 21 19 23, and that death occurred, on the date stated above, at 7:38 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular disease of the heart

CONTRIBUTORY (SECONDARY) Bronchial Asthma

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) J. Anderson, M. D.

, 19 (Address) Froy 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

DATE OF BURIAL July 25 19 20

20. UNDERTAKER Kemper Und Co

ADDRESS Froy 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*, *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 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 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.

1 PLACE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSCounty Linn

491

4298

STANDARD CERTIFICATE OF DEATH

Township

State of

Village

Registered No.

City Gray (No., (Year)

St. Ward

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

2 FULL NAME Mrs Anna Schieber

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) W16 DATE OF DEATH Jan 22, 1923
(Month) (Day) (Year)6 DATE OF BIRTH Nov 20, 1844
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from, 191...., to, 191....,

7 AGE yrs. mos. ds. (If LESS than 1 day, hrs. or min. ?)

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:

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).....

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

10 NAME OF FATHER.....

Contributory (SECONDARY).....

11 BIRTHPLACE OF FATHER (State or country).....

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

12 MAIDEN NAME OF MOTHER.....

(Signed), M. D.

13 BIRTHPLACE OF MOTHER (State or country).....

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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(Informant)

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

(Address)

Where was disease contracted, If not at place of death?

Former or usual residence.....

15 Filed Mar 24, 1922 W P Smith REGISTRAR19 PLACE OF BURIAL OR REMOVAL Strocks Church DATE OF BURIAL Jan 24, 192220 UNDERTAKER e & Niehaus ADDRESS Night City, Mo

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