

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

4467

**1. PLACE OF DEATH**

County FRANKLIN Registration District No. 292 File No. \_\_\_\_\_  
Township BOEUF Primary Registration District No. 5410 Registered No. \_\_\_\_\_  
City BERGER (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** DANIEL HAID JR

(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 50 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) MARRIED  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF HUSBAND OF AMANDA HAID.  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) SEP. 30 - 1859  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
63 4 20

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

9. BIRTHPLACE (CITY OR TOWN) BERGER  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER DANIEL HAID JR

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

12. MAIDEN NAME OF MOTHER TRACE SPECKHALB

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

14. INFORMANT Daniel W. Haid  
(Address) BERGER Mo

15. FILED 2/23/23 W.F. Cumber  
19 23 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 20<sup>th</sup> 1923  
17. I HEREBY CERTIFY, That I attended deceased from Feb 16<sup>th</sup> 1923 to February 20<sup>th</sup> 1923 that I last saw him alive on February 20<sup>th</sup> 1923, and that death occurred, on the date stated above, at 11:30 A.M.

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

466 Acute Peritonitis  
1220 (duration) 2 yrs. 2 mos. 21 ds.  
CONTRIBUTORY Obstruction with perforation  
(SECONDARY) of Bowel (duration) 2 yrs. 2 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED at place of death  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? 1183 No DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) Werner H. Wagner, M.D.  
, 19 (Address) Berger, 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 EVANG ST JOHN'S DATE OF BURIAL FEB 23 19 23

20. UNDERTAKER HERMAN BLUMER ADDRESS BERGER Mo.

PARENTS

# 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 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 *septicæmia*," "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, septicæmia, 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 Franklin State MISSOURI Registered No. 292  
 Township Basin or Village 5410 or  
 City \_\_\_\_\_ No. \_\_\_\_\_ St., \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniel Kaid Sr.  
 (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 M  
(write the word)

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

6 DATE OF BIRTH (month, day, and year) Sep 30 1859

7 AGE Years Months Days 63 4 29  
If LESS than day, hrs. or min.

### 8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grain Dealer  
 (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 Filled \_\_\_\_\_, 19 1911  
W. F. Cimbrell  
 REGISTRAR

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1923

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:

Acute Peritonitis

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

CONTRIBUTORY Obstruction with perforation  
(SECONDARY)  
of bowels due to carcinoma  
 (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) W. H. Wagner, M. D.

, 19 (Address) Berger, 1 mo

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19 PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTAL

CAUSE OF DEATH in plain terms, so that it may be properly certified. See instructions on back of certificate. TION is very important.

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