

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

8079

1. PLACE OF DEATH

County Callaway Registration District No. 104 File No. 1
 Township Wells Primary Registration District No. 3008 Registered No. 48
 City Wells (No. 1) St. Wells Ward 1

2. FULL NAME

Ray M Schaubert
 (a) Residence. No. Julius St. Wells Ward. 1
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U.S., if of foreign birth? 2 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-11-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 — —

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House wife
 (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) Wells Mo

10. NAME OF FATHER Don Kues

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wells Mo

12. MAIDEN NAME OF MOTHER Donna Kues

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Wells Mo

14. INFORMANT (Address) Resident Hospital not Julius

15. FILED Mar 21 1923 W. J. Lewis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 24 1923

17. I HEREBY CERTIFY, That I attended deceased from 12th 1923 to March 20 1923
 that I last saw h. alive on March 29 1923, and that death occurred, on the date stated above, at 5:15 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Unemphatic
108
84
1915 (duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) By chronic
 (duration) 2 yrs. — mos. — ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF —

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) H. J. Young M.D.
Wells (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 Wellsville Mo. DATE OF BURIAL 3/22 1923

20. UNDERTAKER Wynmore Brothers ADDRESS Fulton 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 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.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

FEDERAL BUREAU OF INVESTIGATION

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Callaway 104 State MISSOURI Registered No. _____
 Township 3008 or Village _____ or _____
 City Fulton No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ray M. Schankurite
 (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				
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>W</u>		
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____				
6 DATE OF BIRTH (month, day, and year) _____				
7 AGE	Years	Months	Days	IF LESS than 1 day, ____ hr. of ____ 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 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) _____			

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) <u>Mar 20 1923</u>
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: <u>neumonia Saker</u>
CONTRIBUTORY (SECONDARY) _____ (duration) <u>10/0</u> 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.)

14 Informant _____ (Address) _____
 15 Filed May 17 1923 [Signature]
REGISTRAR

19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____	DATE OF BURIAL _____ 19____
20 UNDERTAKER _____	ADDRESS _____

SUPPLEMENTAL

BACK OF CERTIFICATE

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