

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

S. 503
35

1. PLACE OF DEATH

County Lafayette Registration District No. 461 File No. 35
Township Springton Primary Registration District No. 5625 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Henry B. Encke
(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. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1923

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Eliza Encke

17. I HEREBY CERTIFY That I attended deceased from Oct 24 1922 to Mar 10 1923, and that I last saw him alive on Mar 10 1923, and that death occurred, on the date stated above, at 6:25 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 22 - 1858

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	64	3	20	

131 (duration) yrs. mos. da.

8. OCCUPATION OF DECEASED Farmer
(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

CONTRIBUTORY (SECONDARY) 129 (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) St. Charles Co Mo.
(STATE OR COUNTRY)

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

10. NAME OF FATHER Jacob Encke

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? L.M. Osborn (Signed) _____, M. D.

12. MAIDEN NAME OF MOTHER No record

Mar 12, 1923 (Address) Lexington, Mo

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

*State the DISEASE CAUSING DEATH, or in death 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 Mrs H. B. Encke
(Address) Lexington Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lexington Mo DATE OF BURIAL Mar 14 1923

15. FILE Mar 12 1923 J. D. Cope REGISTRAR

20. UNDERTAKER Ernest Tegert ADDRESS Lexington Mo

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Lafayette ⁴⁶¹ State MISSOURI Registered No. _____
 Township Keokuk ⁵⁶²⁵ or Village _____ ³⁵ or
 City _____ No. _____ St., _____ Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Henry B Emke
 (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 (write the word) M

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, ____ hrs.
or ____ 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) _____

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) Germany

14 Informant _____
(Address) _____

15 Filed July 9, 1923 J. D. Cope
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 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:

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

CONTRIBUTORY
(SECONDARY)

18 Where was disease contracted (duration) _____ yrs. _____ mos. _____ ds.

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.)

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

19

20 UNDERTAKER _____ ADDRESS _____

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SUPPLEMENTAL

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