

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

5023

**1. PLACE OF DEATH**

County Lewis Registration District No. 483 File No. \_\_\_\_\_  
 Township Wiegans Primary Registration District No. 4292 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. ~~MARRIED~~ ~~WIDOWED~~ OR ~~DIVORCED~~ HUSBAND OF Elizabeth Leher (or) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 3-1849

7. AGE YEARS MONTHS DAYS  
73 10 1  
 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Dealer Retired Real Estate  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Calvert Leher

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

12. MAIDEN NAME OF MOTHER Sarah A. Stone

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

14. INFORMANT Mrs. Doris Koenig  
 (Address) W. Williams town

15. FILED 3-9, 1923 H. L. Johnson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 4th 1923

17. I HEREBY CERTIFY That I attended deceased from Feb 20th 1923, to Mar 1st 1923, that I last saw him alive on Mar 1st 1923, and that death occurred, on the date stated above, at 7:30 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Valvular Heart Disease  
Mitral Insufficiency

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) one yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? NO AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination  
 (Signed) F. B. Parker, M. D.  
 , 19 (Address) Williams town 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 Kahoka Mortuary DATE OF BURIAL Mar 7 1923

20. UNDERTAKER Gertrude Beckel ADDRESS Wycross

715

# 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 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 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.

# STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

**1 PLACE OF DEATH**  
 County Lewis 483 State MISSOURI. Registered No. \_\_\_\_\_  
 Township 4292 or Village \_\_\_\_\_ or  
 City Williamstown No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

**2 FULL NAME** R. C. Lehen  
 (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**

**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 24 1923

**5a** ~~Married, widowed, or divorced~~  
 HUSBAND of Elizabeth Lehen  
 (or) WIFE of \_\_\_\_\_

**17** I HEREBY CERTIFY, That I attended deceased from Feb 20, 1923, to Mar 11, 1923, that I last saw him alive on Mar 11, 1923, and that death occurred, on the date stated above, at 1300 m.

**6 DATE OF BIRTH** (month, day, and year) May 3 - 1849

The CAUSE OF DEATH\* was as follows:

**7 AGE** Years 73 Months 10 Days 1  
IF LESS than 1 day, hrs. or min.

Valvular Heart Disease  
Myocardial Insufficiency  
 (duration) 2 1/2 yrs. mos. ds.

**8 OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Dealer  
Retired Real Estate  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

**CONTRIBUTORY** Stroke of Infarct  
 (SECONDARY) (duration) 1 1/2 yrs. mos. ds.

**9 BIRTHPLACE** (city or town) Clark Co Mo  
 (State or country)

**18** Where was disease contracted  
 If not at place of death? \_\_\_\_\_

**10 NAME OF FATHER** Calith Lehen

Did an operation precede death? No Date of \_\_\_\_\_

**11 BIRTHPLACE OF FATHER** (city or town) Warrens  
 (State or country)

Was there an autopsy? No

**12 MAIDEN NAME OF MOTHER** Anna M. Stone

What test confirmed diagnosis? Physical Exam  
 (Signed) F. B. Parker, M. D.

**13 BIRTHPLACE OF MOTHER** (city or town) Ohio  
 (State or country)

, 19 (Address) Williamstown Mo  
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**14 Informant** Mad. Dicie Wasserman  
 (Address)

**19 PLACE OF BURIAL, CREMATION, OR REMOVAL** Wheeler's Cemetery **DATE OF BURIAL** Mar 7 1923

**15 Filed** Mar 24 1923 F. B. Parker  
 REGISTRAR

**20 UNDERTAKER** Kurt H. Baskett **ADDRESS** Wyersford

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.

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