

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

10830

1. PLACE OF DEATH

County W. Lewis Registration District No. 231 File No. 2665
 Township W. Lewis Primary Registration District No. 000 Registered No. 2665
 City McPherson (No. 6123) McPherson Ave. St. 9 Ward

2. FULL NAME

Elizabeth Ann Rortter

(a) Residence. No. 6123 McPherson St. 9 Ward. (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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Arnold P. Rortter
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 19 1889
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 84 21
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work at home (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) MARCH 10 1923
 17. I HEREBY CERTIFY, That I attended deceased from Jan 1920 to March 10 1923 that I last saw her alive on March 10 1923, and that death occurred, on the date stated above, at 11:20 p.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
87A
82D
97 Paralysis (duration) 3 yrs. mos. da.
 CONTRIBUTORY Arterio sclerosis (SECONDARY) (duration) 3 yrs. - mos. - da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? _____
 19. DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? NO
 WHAT TEST CONFIRMED DIAGNOSIS? General examination
 (Signed) H. S. Moulton, M. D.
 , 19 (Address) 537 N. Grand Ave.

*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 Bellefontaine County DATE OF BURIAL March 13 1923
 20. UNDERTAKER C. R. Lupton ADDRESS 4449 Olive St

9. BIRTHPLACE (CITY OR TOWN) Cassel (STATE OR COUNTRY) Germany
 10. NAME OF FATHER Henry Schmidt
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Mrs. Rortter
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Elizabeth D. Nash (Address) 6123 McPherson
 15. FILED W. L. Starkeoff REGISTRAR

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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County 791 State MISSOURI Registered No. 2665
 Township 1003 or Village _____ or _____
 City St. Louis No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Ann Roetter
 (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 <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, hrs. or 2 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 10 1923</u>
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>Paralysis Hemiplegia</u> <u>of cerebral hemisphere</u> <u>apoplexy</u> <u>information given over</u> <u>phonograph Dr. H. P. Montague</u> (duration) _____ yrs. <u>5-18-23</u> ds. 18 Where was disease contracted _____ If not at place of death? <u>Dir of D-S</u> Did an operation precede death? _____ Date of _____ Was there an autopsy? _____ What test confirmed diagnosis? _____ (Signed) <u>[Signature]</u> , 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)	19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
15 Filed <u>MAY 18 1923</u> <u>Max & Starkloff</u> REGISTRAR	20 UNDERTAKER	19 _____ ADDRESS

SUPPLEMENTAL

TION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

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