

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

13159

1. PLACE OF DEATH

County Johnson Registration District No. 435 File No. 10
 Township Johnson Primary Registration District No. 5592 Registered No. 18
 City _____ (No. _____) 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Jas. Rader
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1, 1885
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 9 _____
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
 (STATE OR COUNTRY) Adrian Michigan
 10. NAME OF FATHER Adrian W. Wenzel
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Jolly Dalton
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
 (STATE OR COUNTRY) _____

14. INFORMANT Geo. Rader
 (Address) Adrian Mo.

15. FILED April 10, 23 R. L. Schaefer
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/2 1923
 17. I HEREBY CERTIFY that I attended at Adrian from 3/31 to 4/2 1923 that I last saw her alive on 3/31 1923, and that death occurred, on the date stated above, at _____
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
(Interstitial)
151 (duration) _____
162 (duration) _____
 CONTRIBUTORY (SECONDARY) Dementia (duration) _____ 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? Microscopic
 (Signed) R. Schaefer, M. D.
4/3, 1923 (Address) Adrian Mo.
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state 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 Int. Labor Cem. DATE OF BURIAL 4/4 1923

20. UNDERTAKER L. C. Newman ADDRESS Adrian

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 Johnson 435 State MISSOURI Registered No. _____
 Township Jackson 5592 or Village _____ 18 or _____
 City _____ No. _____ St., _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth M. Rader

(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 <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>		16 DATE OF DEATH (month, day, and year) <u>4-2</u> 19 <u>23</u>	
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Gas Rader</u>				17 I HEREBY CERTIFY , That I attended deceased from <u>3/31</u> , 19 <u>23</u> , to <u>3/31</u> , 19 <u>23</u> that I last saw her alive on <u>3/31</u> , 19 <u>23</u> and that death occurred, on the date stated above, at _____ m.	
6 DATE OF BIRTH (month, day, and year) <u>July 1 - 1837</u>				The CAUSE OF DEATH* was as follows: <u>Chronic Nephritis</u> <u>interstitial</u>	
7 AGE	Years <u>84</u>	Months <u>9</u>	Days _____	IF LESS than 1 day, _____ hrs. or _____ min.	
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				CONTRIBUTORY <u>Senility</u> (duration) _____ yrs. _____ mos. _____ ds.	
9 BIRTHPLACE (city or town) <u>Pa</u> (State or country) _____				18 Where was disease contracted if not at place of death? _____	
10 NAME OF FATHER <u>Adam Wolfberger</u>				Did an operation precede death? <u>No</u> Date of _____	
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____				Was there an autopsy? <u>No</u>	
12 MAIDEN NAME OF MOTHER <u>Sully Dalton</u>				What test confirmed diagnosis? <u>Clinical</u>	
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____				(Signed) <u>T. C. Schooley</u> , M. D. <u>3</u> , 19 <u>23</u> (Address) <u>Odessa Mo</u>	
14 Informant <u>Gas Rader</u> (Address) <u>Odessa Mo</u>				* 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.)	
15 Filed <u>May 18, 1923</u> <u>L. J. Turnbull</u> REGISTRAR				19 PLACE OF BURIAL, CREMATION, OR REMOVAL <u>M + Labor Cem</u> DATE OF BURIAL <u>4/4</u> 19 <u>23</u>	
20 UNDERTAKER <u>L. C. Husman</u>				ADDRESS <u>Odessa</u>	

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