

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

36112-a

8 25 1927

1. PLACE OF DEATH

County Boon Registration District No. 1159 File No. _____
 Township Boon Precinct No. _____ Registered No. 1
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Edna Margaret Rochas

(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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS
4 8 8
 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) Boon County Mo

10. NAME OF FATHER Herman Rochas

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) St Louis Mo

12. MAIDEN NAME OF MOTHER Edna Schulz

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

14. INFORMANT Herman Rochas
 (Address) Bellevue Mo

15. FILED Feb 6 1927 Blvd Bynum
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15 1923
17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1923, to Dec 15 1923, that I last saw him alive on Dec 15 1923, and that death occurred, on the date stated above, at 8 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Spinal Meningitis (duration) yrs. mos. 4 ds.
CONTRIBUTORY (SECONDARY) Typhoid fever (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? No
 (Signed) H. L. Kurligson, M. D.
 , 19 (Address) Bismarck 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 Bismarck Mo **DATE OF BURIAL** 12-17 1923

20. UNDERTAKER Heil **ADDRESS** Bismarck

COPY - Exact Statement of Death - F DEATH in plain terms, so that it

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*, *peritonium*, 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 suicidal*. 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PLACE OF DEATH
County Crow
Township 11
City 11

Registration District No. 1159
Primary Registration District No. 2549

File No. _____
Registered No. 1
St. _____ Ward _____

FULL NAME Edna Margaret Roches
(a) Residence. No. _____
(Usual place of abode)
Place of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

SEX F 4. COLOR OR RACE A. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED A.

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

DATE OF BIRTH (MONTH, DAY AND YEAR) April 7 1919

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>4</u>	<u>8</u>	<u>8</u>	

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 _____

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15 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 _____, Mo.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

CONTRIBUTORY (SECONDARY) _____ (duration) _____ 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.)

INFORMANT _____
(Address) _____

FILED _____ 19____ 1923 REGISTRAR

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

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

11.24.76