

N. B.—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.

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

1 PLACE OF DEATH  
County Cape Girardeau  
Township Randol Registration District No. 131 File No. 7083  
or  
Village Primary Registration District No. 5782 Registered No.  
or  
City (NO. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Hannah Stente

| PERSONAL AND STATISTICAL PARTICULARS   |  |   |  | MEDICAL CERTIFICATE OF DEATH |  |
|--|--|---|--|------------------------------|--|
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>White</u>  | 5 SINGLE MARRIED WIDOWED OR DIVORCED<br><u>Married</u><br>(Write the word)  | 16 DATE OF DEATH<br><u>Mar 21</u> 19 <u>24</u><br>(Month) (Day) (Year)   |                              |  |
| 6 DATE OF BIRTH<br><u>April 12</u> 18 <u>93</u><br>(Month) (Day) (Year)  |  |   | 17 I HEREBY CERTIFY, that I attended deceased from<br><u>October 20</u> 19 <u>23</u> to <u>Mar 21</u> 19 <u>24</u><br>that I last saw her alive on <u>Mar 20</u> 19 <u>24</u><br>and that death occurred, on the date stated above, at <u>2:30 P.</u> m. |                              |  |
| 7 AGE<br><u>31</u> yrs. <u>11</u> mos. <u>8</u> ds.  | IF LESS than<br>1 day.....hrs.<br>or.....min.?   |   | The CAUSE OF DEATH* was as follows:<br><u>Nervous Prostration</u>  |                              |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>House work</u>                                 |  |   | 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)<br><u>11</u> yrs. <u>3</u> mos. <u>21</u> ds.  |                              |  |
| (b) General nature of industry business or establishment in which employed (or employer)                               |  |   | CONTRIBUTORY (Secondary)<br><u>Influenza</u>   |                              |  |
| 9 BIRTHPLACE<br>(City or town, State or foreign country)<br><u>Cape Girardeau Mo</u>                                   |  |   | (Signed) <u>Oliver J. Miller</u> M. D.<br><u>Mar 21</u> 19 <u>24</u> (Address) <u>Cape Girardeau Mo</u>  |                              |  |
| PARENTS  | 10 NAME OF FATHER<br><u>Henry Kerkner</u>  | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.                      |  |                              |  |
|  | 11 BIRTHPLACE OF FATHER<br>(City or town, State or foreign country)<br><u>Hannover Germany</u> | 18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)<br>At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds. |  |                              |  |
|  | 12 MAIDEN NAME OF MOTHER<br><u>Louise Koppel</u>   | Where was disease contracted if not at place of death?<br>Former or usual residence.....  |  |                              |  |
| 13 BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country)<br><u>Cape Gir Co Mo</u>                           |  |   | 19 PLACE OF BURIAL OR REMOVAL<br><u>Cape Gir Mills Cem</u>   |                              |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Ag. Heule</u><br>(Address) <u>Cape Gir Mills Mo</u> |  |   | DATE OF BURIAL<br><u>Mar 24</u> 19 <u>24</u>   |                              |  |
| 15 Filed <u>May 9</u> 19 <u>24</u> <u>O. J. Miller</u><br>Registrar  |  |   | 20 UNDERTAKER<br><u>Dr. Koppel &amp; Co</u>  |                              |  |
|  |  |   | ADDRESS<br><u>Cape Girardeau Mo</u>  |                              |  |

# 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "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.)