

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

28753

1. PLACE OF DEATH

(County) Nodaway Registration District No. 620 File No. _____
 Township _____ Primary Registration District No. 4371 Registered No. _____
 City Clyde (No. _____) St. _____ Ward _____

2. FULL NAME

Sister Mary Heltrudis Homan
 (a) Residence No. Convent Clyde Mo, St. Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 9 yrs. mos. _____ ds. How long in U.S., if of foreign birth? yrs. mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-2-1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
33 | 2 | 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coffler
 (b) General nature of industry, business, or establishment in which employed (or employer) Convent of
 (c) Name of employer Perpetual Adoration

9. BIRTHPLACE (CITY OR TOWN) Padua
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Henry Homan

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

12. MAIDEN NAME OF MOTHER Mary Krug

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

14. INFORMANT S. M. Ouphennia
 (Address)

15. FILED Oct 30 24 Mabel Menzies
 19. _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-27-1924

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____
When 1924, to _____ 19____
 that I last saw her alive on July 17, 1924, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
7:00 PM (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Myocarditis
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH? _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examination
 (Signed) Wm J. Ryan M. D.

(Address) 412 Lafayette Bldg
 *State the DISEASE CAUSING DEATH, or in death 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 Convent Burial ground. DATE OF BURIAL 9-27-1924

20. UNDERTAKER _____ ADDRESS _____

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 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," "Anomia" (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.

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

1. PLACE OF DEATH

County Wodaway Registration District No. 620 File No. _____
 Township Jeffersville Primary Registration District No. 4371 Registered No. _____
 City Clyde (No. _____) St. _____ Ward _____

2. FULL NAME

Sister Mary Hiltrudis Roman
 (a) Residence. No. 222 West Clyde Ward 1st (If nonresident give city or town and State)
 (Usual place of abode) Mo
 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-2-1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 2 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cobbler
 (b) General nature of industry, business, or establishment in which employed (or employer) Convent - Clyde Mo
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paducah Ky

10. NAME OF FATHER Henry Roman

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

12. MAIDEN NAME OF MOTHER Mary King

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

14. INFORMANT Dr M Euphemus
 (Address) _____

15. FILED 9/30 1924 Mabel M. Grabau REGISTRAR
ingay

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-25 1924
 17. _____

I HEREBY CERTIFY, That I attended deceased from May 1 1924, to July 7, 1924, and that I last saw him live on July 7, 1924, and that death occurred, on the date stated above, at 7-25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Summery Tuberculosis
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) John J. Byrne M. D.
 , 19 24 (Address) St Louis 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 Convent - Clyde Mo DATE OF BURIAL 9-27 1924

20. UNDERTAKER Carl Kohlhaapel ADDRESS Clyde Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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