

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.

V. S. 4

Has decedent ever served in military or naval service of U. S. ?

1. PLACE OF DEATH Registration **St. Charles** Dist. No. **756**  
 County of **St. Charles**  
 (Show on line below the name of place where death occurred; give either City (or Village) or Township (or Road District), not both.)  
 Township, or Road District, or Village, or City, of **West Alton mo** Primary Dist. No. **5997**  
 Registered No. **6** (Consecutive No.)  
 Street and Number, No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward, \_\_\_\_\_ Hospital.

Department of Public Health—Division of Vital Statistics  
**STANDARD CERTIFICATE OF DEATH** 12738  
 (If death occurred in hospital or institution, give its name instead of street and number)

2. FULL NAME **Henry Wagemann Sr.**  
 Residence No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward, \_\_\_\_\_ Hospital.  
 (Usual place of abode) (If non-resident give city or town and State)  
 Length of residence in city or town where death occurred **6** yrs. **0** mos. **0** ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH	
3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <b>Married</b> (Write the word)	16. DATE OF DEATH <b>April 28</b> , 19 <b>25</b> (Month) (Day) (Year)		17. I HEREBY CERTIFY, That I attended deceased from <b>4/1</b> , 19 <b>25</b> , to <b>4/4</b> , 19 <b>25</b> , that I last saw h..... alive on <b>4/27</b> , 19 <b>25</b> , and that death occurred, on the date stated above, at <b>8 A. m.</b> The CAUSE OF DEATH* was as follows: <b>2nd Passer strangulation</b> <b>of the throat</b> <b>1627 13ram</b> (Duration) .....yrs. ....mos. <b>6</b> ds. Contributory (Secondary) <b>Acidosis</b> (Duration) <b>1</b> yrs. ....mos. ....ds.	
8a. If married, widowed or divorced HUSBAND of (or) WIFE of <b>Meta Wagemann</b>	6. DATE OF BIRTH <b>August 25</b> , 19 <b>47</b> (Month) (Day) (Year)	7. AGE Years <b>77</b> Months <b>8</b> Days <b>3</b> If LESS than 1 day.....hrs. OR.....min.?	18. WHERE WAS DISEASE CONTRACTED If not at place of death?..... Did an operation precede death? <b>no</b> Date of..... Was there an autopsy? <b>no</b> What test confirmed diagnosis? <b>usual</b> (Signed) <b>Dr. Brownson</b> M. D. Address <b>110 2 5 - Alton Ill</b> Date <b>4/4</b> , 19 <b>25</b> Telephone <b>1621</b>			
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) <b>Germany</b>	10. NAME OF FATHER	11. BIRTHPLACE OF FATHER (city or town) (State or Country) <b>Germany</b>		12. MAIDEN NAME OF MOTHER	
		13. BIRTHPLACE OF MOTHER (city or town) (State or Country) <b>Germany</b>	14. INFORMANT, <b>Henry Wagemann Jr.</b> Address <b>West Alton Mo</b>		15. FILED <b>Apr. 29 1925</b> <b>C. A. Barnard</b> Registrar. (P. O. Address) <b>Portage Des Lions Mo</b>	
			19. PLACE OF BURIAL OR REMOVAL <b>Evergreen Cemetery</b>		20. UNDERTAKER <b>John A. Hochm</b>	
			21. DATE OF BURIAL <b>May 1</b> , 19 <b>25</b>		ADDRESS <b>Alton Ill</b>	

\*N. B.—State the disease causing death. All cases of death from "Violence, casualty, or any undue means" must be referred to the coroner. See Section 10, Coroner's Act. (See reverse side.)  
**License # 1842**

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, eg., *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) *Saleman*, (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 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 that 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, meningis, peritonaeum*, 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," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical-operation was undertaken. (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

All deaths from "violence, casualty, or any undue means" must be referred to the coroner; A MEDICAL CERTIFICATE OF DEATH IN SUCH CASES DOES NOT COMPLY WITH THE REGISTRATION LAW OF ILLINOIS. See Section 10, Coroner's Act.

### The following list of indefinite terms will not be accepted as cause of death unless explained:

Abscess—Locate and describe.  
 Accident—Refer to Coroner.  
 Albuminuria—Disease causing?  
 Angina—Was it scarlet fever or diphtheria?  
 Ascites—Disease causing?  
 Asphyxia—Accidental, suicidal—cause?  
 Asthenia—State cause.  
 Atrophy—Cause of — tuberculosis, syphilis?  
 Auto {infection } Cause of?  
 {intoxication }  
 Bowel trouble—Name disease; diarrhoea, dysentery, enteritis, strangulation?  
 Blood poisoning—State cause.  
 Bottle feeding—What disease resulted?  
 Breaking down—What disease?  
 Cachexia—Cancer, syphilis, tuberculosis, malarial?  
 Cancer—Primary location.  
 Cardiac {Asthenia } Not accepted.  
 {Debility }  
 {Failure }  
 {Weakness }  
 Collapse—From what?  
 Cold—Not accepted.  
 Childbirth — Physiological — what caused death?

Cellulitis—Give location and cause.  
 Coma—Cause {alcoholic?  
 {opium, etc.?  
 {epileptic—puer-  
 {peral?  
 {children, diar-  
 {rhoea, enteritis?  
 Convulsions—Cause  
 Cramps—State cause of.  
 Cyanosis—Cause of—  
 Decline—State cause of.  
 Debility—From what disease?  
 Delirium {alcoholic?  
 {traumatic?  
 Dentition—Disease causing death?  
 Dropsy—Name disease causing.  
 Dyspepsia—what organic disease?  
 Eclampsia—State cause of convulsions.  
 Emphysema—State cause.  
 Exhaustion—State cause of.  
 External Violence—Refer to Coroner.  
 Failure of vital powers—What disease?  
 Feebleness—What disease?  
 Gastritis—State cause of.  
 Heart failure—See cardiac.  
 Hemorrhage—What part, and cause?  
 Inanition—Cause of?  
 Insolation (under 24 hours) (Coroner)?  
 Jaundice—Disease causing?  
 Malnutrition—Cause of?

Marasmus—What disease?  
 Milk infection {diarrhoea?  
 {enteritis?  
 Miscarriage—State cause of.  
 Nervous {exhaustion } State  
 {fever } disease.  
 {shock }  
 Old age—What disease?  
 Operation—State part and disease.  
 Paresis—General paralysis of the insane, or not?  
 Peritonitis—Cause of?  
 Pernicious anemia {malarial?  
 {tuberculosis?  
 {syphilis, etc.?  
 Pneumonia {Broncho? } Primary or  
 {Lobar? } Secondary  
 { } to what?  
 Pyæmia—Cause of?  
 Salpingitis—Cause of?  
 Septicæmia—Cause of?  
 Shock—From what?  
 Surgical {operation } State disease.  
 {shock }  
 Syncope—State cause of.  
 Tetanus—State cause of.  
 Toxæmia—State cause of.  
 Uræmia—Acute or chronic nephritis.  
 Weakness—What disease?

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

**1. PLACE OF DEATH**

County St. Charles Registration District No. 756 File No. ....  
 Township ..... Primary Registration District No. 2997 Registered No. ....  
 City ..... (No. ....) St. .... Ward)

**2. FULL NAME**

Henry Wagemann Sr.  
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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 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)

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)

14. INFORMANT (Address)

15. FILED July 27, 1925 C. O. Damard REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1925

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw him alive on ..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Passive congestion of the brain  
apoplexy  
 (duration) yrs. mos. ds.

CONTRIBUTORY injury and  
hypertension  
 (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.  
 , IS (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.)

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

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

SUPPLEMENTARY

PARENTS

# 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*.

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"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 neoplasm); *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.

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