

PLACE OF DEATH: County Platte

694

4416

Township

City Farley

Registered No.

St.

Ward

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

FULL NAME Margaret Schimmel(a) Residence. No. Farley Mo

St.

Ward

(Usual place of abode.)

(If nonresident, give city or town and state.)

(b) 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

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow16 DATE OF DEATH (month, day, and year) 192617 I HEREBY CERTIFY, That I attended deceased after death, 1926, to 3-17, 1926, that I last saw her alive on 3-9, 1926.5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Schimmeland that death occurred, on the date stated above, at 2:45 p. m.6 DATE OF BIRTH (month, day, and year) Aug 31, 1849

The CAUSE OF DEATH * was as follows:

7 AGE Years Months Days If LESS than 1 day.....hrs. or.....min. 76 5 1492B Don't know
90W
duration yrs. mos. ds.8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work House wife (b) General nature of industry, business, or establishment in which employed (or employer)CONTRIBUTORY Prostate Enlargement (Secondary) (duration) Indefinite yrs. mos. ds.9 BIRTHPLACE (city or town) (State or country) Genesee Louisiana

18 Where was disease contracted If not at place of death?

10 NAME OF FATHER Jacob TrimmDid an operation precede death? no Date of11 BIRTHPLACE OF FATHER (City or town) G. BelgiumWas there an autopsy? no(State or country) GermanyWhat test confirmed diagnosis? no (Signed) D. H. Mountain M. D.12 MAIDEN NAME OF MOTHER Kathleen Kertz, 192 (Address) Winton Mo13 BIRTHPLACE OF MOTHER (City or town) Germany

* 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.)

(State or country) GermanyInformant Mat Kathleen Trimm19 PLACE OF BURIAL, CREMATION OR REMOVAL Leavenworth Kansas DATE OF BURIAL Mar 20 1926(Address) Leas Kansas20 UNDERTAKER H. O. O'Connell ADDRESS Leavenworth Kansas

15 Filed.....192

Registrar

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 organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

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

**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 Platte Registration District No. 14 File No. _____
 Township Osley Primary Registration District No. 16 Registered No. _____
 City (No. _____) St. _____ Ward _____
 FULL NAME Margaret Dekummel
 (a) Residence, No. Osley, Mo Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1926

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

17. was called after death
 I HEREBY CERTIFY That I attended deceased from _____
 that I last saw him alive on 3-9-26 and that death occurred, on the date stated above, at _____ m.

DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 31 1847

THE CAUSE OF DEATH WAS AS FOLLOWS:
Don't know

AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 5 14

OCCUPATION OF DECEASED

CONTRIBUTORY (SECONDARY) probably due to indigestion indefinite

(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 _____

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Peru, Ind

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? no

NAME OF FATHER Jacob Dekum

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Belgium

19. WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? (Signed) C. J. Chapman, M. D.
 Address Preston, Mo

MAIDEN NAME OF MOTHER Elizabeth Kusch

BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

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Address Miss Catherine Kusch, Leos, Kansas

PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Leos, Kansas 3/10 1926

19. _____
 Registrar Elizabeth Kusch

20. UNDERTAKER ADDRESS L. J. O'Donnell, Leos, Kansas

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. If the age is not known, state the best estimate. If the sex is not known, state so. If the race is not known, state so. If the color is not known, state so. If the date of birth is not known, state so. If the date of death is not known, state so. If the cause of death is not known, state so. If the place of death is not known, state so. If the place of burial is not known, state so. If the name of the undertaker is not known, state so. If the name of the registrar is not known, state so. If the name of the physician is not known, state so. If the name of the hospital is not known, state so. If the name of the cemetery is not known, state so. If the name of the funeral home is not known, state so. If the name of the mortuary is not known, state so. If the name of the embalmer is not known, state so. If the name of the funeral director is not known, state so. If the name of the funeral home is not known, state so. If the name of the mortuary is not known, state so. If the name of the embalmer is not known, state so. If the name of the funeral director is not known, state so.

**TEMPORARILY
RECEIVED**

Revised United States Standard Certificate of Death

Whooping cough; Chronic valvular heart disease
Chronic interstitial nephritis, etc. The contributory (see
instructions) affection need not be stated

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health
Association.)

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"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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.)

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