

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

1. PLACE OF DEATHCounty.....Ruchanan.....Registration District No. 85

Township.....

Primary Registration District No. 1001City.....St. Joseph,.....(No. St. Joseph, s. Hospital)File No. 11614Registered No. 417

St.

Ward)

2. FULL NAMEEva Lieb(a) Residence. No. 2102 North 2nd Street..... St.

(Usual place of abode)

Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 3 mos. 24 da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS**3. SEX**Female**4. COLOR OR RACE**White**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**Married.**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**Albert Lieb.**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Dec 24, 1876**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

4932425**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....

Household.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) St. Joseph,

(STATE OR COUNTRY)

Missouri.**10. NAME OF FATHER** Joseph Herner.**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** Columbus.

(STATE OR COUNTRY)

Ohio.**12. MAIDEN NAME OF MOTHER** Lary Dannecker.

(STATE OR COUNTRY)

Wisconsin.**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** Unknown.

(STATE OR COUNTRY)

14.INFORMANT.....Albert Lieb.

(Address)

2102 North 2nd Street,**15.**

FILED

APR 21 1926John B. W.

REGISTRAR

3**MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)** April 18 1926**17.**I HEREBY CERTIFY. That I attended deceased from
9 1926 to April 18, 1926
(that I last saw him/her alive on April 18, 1926, and that death occurred, on the date stated above, at 5/30 P.M.**THE CAUSE OF DEATH* WAS AS FOLLOWS:**collapse of trachea
(after having the tracheotomy)
(A.E. Clark told) (Autopsy Total)
10/5/26 (duration) yrs. mos. da.**CONTRIBUTORY (SECONDARY)**adenoma of thyroid(duration) 20 yrs. mos. da.**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

/ DID AN OPERATION PRECEDE DEATH? Yes DATE OF April 9 - 26WAS THERE AN AUTOPSY? YesWHAT TEST CONFIRMED DIAGNOSIS? Autopsy(Signed) H. H. Walker, M. D.Apr 19, 1926 (Address) 301 N. 5th St. Joseph, 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**DATE OF BURIAL**Mount Olivet CemeteryApr 21 1926**20. UNDERTAKER****ADDRESS**H. O. Sidenfuder1802 Union St.

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, 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No.
Township Primary Registration District No. 1001 Registered No. 417
City St. Joseph (No.) St. Ward)

2. FULL NAME

Eva Lieb

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18 1926

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

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..... m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
collapse of trachea following thyroidectomy, sub-total

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

CONTRIBUTORY (SECONDARY) Adenoma of Thyroid Gm - Carcinoma

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

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? NO DATE OF
WAS THERE AN AUTOPSY? NO

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. L. Wallace M. D.
4/19, 1926 (Address) St. Joseph, Mo.

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)

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14. INFORMANT (Address)

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

15. FILED 4/21, 1926 John B. White REGISTRAR

20. UNDERTAKER ADDRESS

CAUSE OF DEATH IN PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

REGISTRARS SHALL N... IT STATES UP... ED BY LAW

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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