

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

12509

1. PLACE OF DEATH

County Jackson
Township Wau
City Kansas City

Registration District No. 309
Primary Registration District No. 3527 Campbell Sp

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME Lillian M. Emrich
(a) Residence. No. 3527 Campbell St., _____ Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred 44 yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? 46 yrs. _____ mos. _____ da.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Cora S. Emrich

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16 1865

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
60 9 25

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer) Vinigars
(c) Name of employer _____

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

10. NAME OF FATHER Moses Emrich

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

12. MAIDEN NAME OF MOTHER Rose Bodenestueck

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

14. INFORMANT Cora S. Emrich (Address) 3527 Campbell

15. FILED 4/12 26 M. M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 11 1926
17. _____

I HEREBY CERTIFY That I attended deceased from Jan 1, 1926 to April 11, 1926 that I last saw him alive on April 11, 1926, and that death occurred, on the date stated above at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral embolism, followed by softening of brain

CONTRIBUTORY Haemorrhagic nephritis (SECONDARY)
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE LONGER LIVED IF NOT AT PLACE OF DEATH? Home

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Jan 4, 1926

WHAT TEST CONFIRMED DIAGNOSIS? Special studies of spinal fluid

(Signed) Orlando Hoffmann, M. D.
4/12 1926 (Address) 1235 1/2 13th Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE, 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 Rose Hill DATE OF BURIAL Apr 13 1926

20. UNDERTAKER J. J. Davidson ADDRESS 3027 1/2 100th

MARGIN RESERVED FOR BIRDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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, 8 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," "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: "Certificate, 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.

cated by check marks, lacking from the death certificate:

Name:

Silman W. Emrich

form no. *1*

Who died at:

Kansas City Mo on *April 11, 26,*
35 27 Campbell

Residence: No.

St.

(If nonresident, city or town)

Length of residence in city or

town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: *Cerebral Embolism,*

followed by softening of Brain.

Contributory: *Hemorrhagic Nephritis,*

Where was disease contracted? _____

Did operation precede death? *yes* Date of *Jan 4-26*

Was there an autopsy? _____ What test confirmed diagnosis? _____

Clerk Vital Statistics
Kansas City, Mo.

Dear Sir:

Complying with inclosed request
I wish to say that the operation was a supra-
pubic cystostomy for the relief (temporarily) of
an infected bladder due to an hypertrophied
prostate.

Very truly,
Otto von Hofmann.