

DEC 22 1926

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

Do not use this space.

35813

34813

1. PLACE OF DEATH

County *St Charles*Registration District No. *755*Township *Pemine Page*Primary Registration District No. *996A*

City

File No.

Registered No. *9*

St.

Ward)

2. FULL NAME

(a) Residence No.

(Usual place of abode)

Length of residence in city or town where death occurred *54* yrs. mos. ds.

Ward.

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF*Widowed*

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

Jan 2 - 1834

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.*92**10**11*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work*Retired Farmer*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

10. NAME OF FATHER

Jacob Linnemeyer

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Tiemann

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT

(Address)

*Wm. Linnemeyer
Augusta Mo*

15.

FILED *11-13, 1926**B. M. Miller
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

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

Nov. 13 - 1926

17.

I HEREBY CERTIFY That I attended deceased from
Nov. 1, 1926, to *Nov 12, 1926*
that I last saw him alive on *Nov 1, 1926*, and that
death occurred, on the date stated above, at *9 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Senility; Arterio Sclerosis
1864**1926 About 3 yrs
97 (duration) 2 yrs. mos. ds.*CONTRIBUTORY
(SECONDARY)*Fracture of neck of
Femur (duration) yrs. 11 mos. ds.*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? *No* DATE OFWAS THERE AN AUTOPSY? *No*WHAT TEST CONFIRMED DIAGNOSIS *Clinical Symptoms*(Signed) *C. D. Miller*, M. D.*11-13 - 1926 (Address) Has Melle, 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

*Home Cemetery**11-15 - 1926*

20. UNDERTAKER

ADDRESS

*Wm. Phil King
Augusta Mo*

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.)

under taken. For violent
State cause for whi
"Pneumonia",
diseases resulting from
be ascertained as the
"Weakness," etc.,
"Marasmus,"
"Exhaustion," "Heart fail
"Debility" ("Congestive,"
"Atrophy," "Collapse,"
"Anemia," "Asthma,"
report mere symptoms of
29 ds.; *Bronchopneumonia*
portant. Example: *Meas*
tercurrent) affection need
nephritis, etc. The cont
Chronic valvular heart d
for malignant neoplasm);
gin; "Cancer" is less defini
"Carcinoma, Sarcoma," etc.

Precise statement of
so that the relative
ts can be known. The
every person, irrespec
tions a single word or
cient, e. g., *Farmer* or
r, *Architect, Locomo-
Stationary Fireman,*
specially in industrial em
know (a) the kind of
of the business or in
tional line is provided
uld be used only when
inner, (b) *Colton mill,*
) *Foreman, (b) Auto-
worked on may form
nent. Never return
ager," "Dealer," etc.,
tion, as *Day laborer,*
nine, etc. Women at*

home, who are engaged in the duties of the house-
hold 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 be-
ginning of illness. If retired from business, that
fact may be indicated thus: *Farmer (retired, 6*
 yrs.). For persons who have no occupation what-
ever, write *None.*

Statement of Cause of Death.—Name, first, the
DISEASE CAUSING DEATH (the primary affection with
respect to time and causation), u
same accepted term for the same dise
Cerebrospinal fever (the only defini
"Epidemic cerebrospinal meningit
(avoid use of "Croup"); *Typhoid fe*

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-
pneumonia* ("Pneumonia," unqualified, is indefinite);
Tuberculosis of lungs, meninges, peritoneum, etc.,
Carcinoma, Sarcoma, etc., of _____ (name origi-
gin; "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 in-
tercurrent) affection need not be stated unless im-
portant. Example: *Measles* (disease causing death),
29 ds.; Bronchopneumonia (secondary), *10 ds.* Never
report mere symptoms or terminal conditions, such
as "Asthma," "Anemia" (merely symptomatic),
"Atrophy," "Collapse," "Coma," "Convulsions,"
"Debility" ("Congenital," "Coma," etc.),
"Exhaustion," "Heart failure," "Hemorrh
anition," "Marasmus," "Old age," "Shoo
mia," "Weakness," etc., when a definite
be ascertained as the cause. Always
diseases resulting from childbirth or misce
"PUERPERAL septicemia," "PUERPERAL p
etc. State cause for which surgical open
undertaken. For VIOLENT DEATHS state MEANS OF
INJURY and qualify as ACCIDENTAL, SUICIDAL, OR
HOMICIDAL, or as *probably* such, if impossible to de-
termine definitely. Examples: *Accidental drown-
ing; struck by railway train—accident; Revolver wound*
*of head—homicide; Poisoned by carbolic acid—prob-
ably 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 unde-
sirable 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, hemor-
rhage, gangrene, gastritis, erysipelas, meningitis, miscarriage,
necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus."
But general adoption of the minimum list suggested will work
improvement, and its scope can be extended at a later

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 St. Charles Registration District No. 755 File No.
 Township Genere Osage Primary Registration District No. 3996a Registered No. 9
 City (No.) St. Ward)

2. FULL NAME

Ino. E. Linnenbringer
 (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** wid
(write the word)

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 19... B. Mallinckrodt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 13 19 76

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Empty - Arteriosclerosis
Fracture neck of femur by falling
 CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED in farm

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (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

19

20. UNDERTAKER

ADDRESS

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

SUPPLEMENTARY