

FEB 26 1927

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

Do not use this space.

38880 *a*

1. PLACE OF DEATH

County *Montgomery*
Township *Centre*
City *Centre* (No. *5-6*)

Registration District No. *594*
Primary Registration District No. *42.52*

File No. *X 5*
Registered No. *X 5*
St. *Centre* Ward

2. FULL NAME

Robert J Baumgartner
(a) Residence. No. *Centre* St. *Centre* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

6a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary Baumgartner*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 17 1872*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 3 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Rural mail carrier*
(b) General nature of industry, business, or establishment in which employed (or employee) *Do*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Herman Mo*
(STATE OR COUNTRY)

10. NAME OF FATHER *Robert Baumgartner*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Centre Mo*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Caroline Fischer*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Centre Mo*
(STATE OR COUNTRY)

14. INFORMANT *Mary Baumgartner*
(Address) *Centre Mo*

15. FILED *12-19 1926* *O R. Rarschelsch*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 14 1926*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 13 1926* to *Dec 14 1926*
that I last saw him alive on *Dec 14 1926*, and that death occurred, on the date stated above, at *1:30 PM* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Peritonitis
1. *11*
2. *11*
(duration) yrs. mos. *2* da.
CONTRIBUTORY *Rupt Gall Bladder*
(SECONDARY)
(duration) yrs. mos. *7* da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

! DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *Dec 14 26*
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *Cholera & Peritonitis*
(Signed) *O R. Rarschelsch* M. D.
12 19 1926 (Address) *Phineasland 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

St Joseph Cemetery *12-19 1926*
20. UNDERTAKER *Barton Baker* ADDRESS *Amos 11/19*

EXACTLY. PHYSICIANS should state
ment of OCCUPATION is very important.

fully
may be properly
ded.

N. B. -
CAUSE

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 pneum. apia"); *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 Montgomery Registration District No. 594 File No. _____
Township Laurie Primary Registration District No. 578818 Registered No. 5
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.
(If nonresident give city or town and State)

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 Mary Baumgartner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-17-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 3 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rail mail Carrier
(b) General nature of industry, business, or establishment in which employed (or employer) RR
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Herman

10. NAME OF FATHER Robt Baumgartner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Switzerland

12. MAIDEN NAME OF MOTHER Caroline Fischer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Switzerland

14. INFORMANT Mary Baumgartner

(Address) Rhinecland Mo

15. FILED 1-19-26 O.P. Rauschellbach

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1926

17. I HEREBY CERTIFY That I attended deceased from Dec 13 to Dec 14, 1926
that I last saw deceased alive on Dec 14, 1926, and that death occurred, on the date stated above, at 12 PM m.
THE CAUSE OF DEATH WAS AS FOLLOWS:
General Peritonitis
Ruptured gall bladder
(duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 240

IF NOT AT PLACE OF DEATH, DATE OF _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS, Clinical & Section

(Signed) O.P. Rauschellbach, M.D.

12-19-1926 (Address) Rhinecland 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

St Joseph Cemetery 12-19 1926

20. UNDERTAKER

ADDRESS

Barton Baker Amesmo Mo

Every item of information should be carefully examined. AGE could be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION is important. IF ARE COMPLETE AS PRESENTED BY LAWYER. IF FOR PARENTS ONLY.

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