

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

9353

1 PLACE OF DEATH

1927
County St. Charles
Township Marion
or
Village O'Fallon Mo
or
City (NO. St. Ward)

Registration District No. 760 File No.
Primary Registration District No. 6001 Registered No. 9

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

2 FULL NAME Mother Constantia Immhof

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH May 3 1841
(Month) (Day) (Year)

7 AGE 85 yrs. 9 mos. 20 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Waldkirch Baden

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sr. M. Veneranda
(Address) O'Fallon Mo.

15 Filed Nov 13 1927 J. G. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 12 1927
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 22 1927 to Mar 12 1927 that I last saw W alive on Mar 11 1927 and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
97 916
Duration Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary),
Duration 97 yrs. mos. ds.
(Signed) L. N. Josenberger M. D.
Mar 14 1927 (Address) O'Fallon Mo.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL O'Fallon Mo. DATE OF BURIAL March 15 1927

20 UNDERTAKER Mr. Keithley ADDRESS O'Fallon Mo.

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.

FADING, WITH UNFADING

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*, *Houswork*, 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 neoplasms); *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 "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Charles Registration District No. 760 File No. _____
 Township Ladue Primary Registration District No. 6001 Registered No. 9
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Mother Constantine Imms
 (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		4. COLOR OR RACE		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 3-1841</u>					
7. AGE		YEARS	MONTHS	DAYS	
<u>85</u>		<u>X</u>		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 <u>Not known</u>					
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not known</u>					
12. MAIDEN NAME OF MOTHER <u>Not known</u>					
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Not known</u>					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, and that I had saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

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.)

14. INFORMANT (Address) _____

15. FILED 4/13 1927 J. M. Jenkins REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	19____
	ADDRESS

CAUTION: Information should be carefully supplied IN WRITING should state in plain terms, so that it may be properly filed. Exact statement of CAUSE OF DEATH is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFYING DEATHS. THESE ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-9353