

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

DO NOT USE THIS SPACE.

633

1. PLACE OF DEATH

County Chanton Registration District No. 175
 Township Salisbury Primary Registration District No. 5243
 City Shaughnessy St. _____ Ward _____

File No. _____
 Registered No. 2
 St. _____ Ward _____

2. FULL NAME

Louisa Hafemaster
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-2 1929
 17. I HEREBY CERTIFY That I attended deceased from Dec 25, 1928, to Jan 2, 1929
 that I last saw her alive on Jan 2, 1929, and that death occurred, on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile debility caused by abdominal tumor
of Influenza
11B (duration) yrs. mos. 6 ds.
 CONTRIBUTORY (SECONDARY) ✓
1520 (duration) yrs. mos. ds.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-7-1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
80 | 1 | 25

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) W. O. Hawthinson, M. D.
 , 19 (Address) Beaumont Mo

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Housewife
 (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) Germany

10. NAME OF FATHER A. Woepke

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT M. A. Hafemaster (Address) 2017 27th Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lutheran Cemetery DATE OF BURIAL 1/4 1929
 20. UNDERTAKER Winkelmeier & Co ADDRESS Salisbury

15. FILED 1-10 1929 Lawrence REGISTRAR

1120
 235
 0
 0
 0
 0

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; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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,* etc.), 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
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CERTIFICATE OF DEATH**

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Chariton Registration District No. 175 File No. _____
 Township Salisbury Primary Registration District No. 5243 Registered No. 2
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Louisa Hopfenmeister
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 2, 1929 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 to Jan 2, 1929
 (that I last saw her alive on Jan 2, 1929 and that death occurred, on the date stated above, at 6:40 m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Serious debility caused by abdominal tumor and Empyema
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Don't think the tumor was (SECONDARY)
malignant (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED apparently - last airplane
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____
 WAS HERE AN AUTOPSY _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) W. S. Hawkins M. D.
 , 19 (Address) Roanoke 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.

14. INFORMANT (Address) _____

15. FILED 4/10/29 Gust Hawkins REGISTRAR

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

20. UNDERTAKER Winkelmyer Bros ADDRESS Salisbury

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AG. should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHOULD RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE A WRITTEN LAW

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