

DEC 17 1928

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

Do not use this space.

## 1. PLACE OF DEATH

County *Dent*  
Towaship *Texas*  
City (No. St. Ward)

Registration District No. *102-1*  
Primary Registration District No. *53-2*

File No. *41147*  
Registered No.

## 2. FULL NAME

*Emma Matilda Austin*  
(a) Residence, No. St. Ward. (If nonresident give city or town and State)  
(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? *17* yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 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 *Wife*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *7-29-1858*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*69 9 13*

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House wife*  
(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) *Columbus Ind*

## 10. NAME OF FATHER

*John G Schmirke*

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Fosseville Germany*

## 12. MAIDEN NAME OF MOTHER

*Phoebe Little*

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Lephi Penn*

## 14. INFORMANT

(Address) *T. M. Austin*  
*Physe Mo*

## 15. FILED

*1/18 38* *J. A. Kinsinger*  
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-12-1928*

17. I HEREBY CERTIFY That I attended deceased from *Feb 7*, 19*26*, to *May 12*, 19*28*, that I last saw *h. a.* alive on *3-12-1928*, and that death occurred, on the date stated above, at *12 P. m.*

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic interstitial nephritis*

## CONTRIBUTORY (SECONDARY)

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. A. Kinsinger*, M. D.

, 19 (Address) *Physe 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

*Williams Care* *5-13 1928*

## 20. UNDERTAKER

## ADDRESS

*Robt Smith* *Picking Mo*

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, Compositor, 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*; *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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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41147  
Do not use this space.

1. PLACE OF DEATH

(a) County Dent Registration District No. 1035  
 (b) Township Dugas Primary Registration District No. 5372 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Emma Matilda Austin

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 wife  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-29-1858  
 7. AGE YEARS 69 MONTHS 9 DAYS 13 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Columbus (STATE OR COUNTRY) Indiana

FATHER

13. NAME John B. Schunke  
 14. BIRTHPLACE (CITY OR TOWN) Hardcastle (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Phoebe A. Stee  
 16. BIRTHPLACE (CITY OR TOWN) Paris (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) R. W. Austin  
Bellevue mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Williams cem DATE 5/13 1928

19. FUNERAL DIRECTOR (ADDRESS) Robt Smith  
Lecky mo

20. FILED 1/18 1938 J. A. Kiesel  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-12-1928

22. I HEREBY CERTIFY, That I attended deceased from Feb 7 1928 to May 12 1928  
 I last saw him alive on May 12, 1928. Death is said to have occurred on the date stated above, at 12:10 a. m.

The principal cause of death and related causes of importance were as follows:  
Chronic Interstitial nephritis

Other contributory causes of importance: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) R. E. McCallister, M. D.  
 (Address) Lecky mo

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

