

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.

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

PLACE OF DEATH  
County Lincoln  
Township Beard Oak Registration District No. 487 File No. 38664  
or Village Foley Mo Primary Registration District No. 4254 Registered No. 12  
or City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Nicholas Mildeustrin

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>Dec 13</u> , 191 <u>0</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Feb 8</u> , 18 <u>45</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Sept</u> , 191 <u>0</u> , to <u>Dec 12</u> , 191 <u>0</u> , that I last saw him alive on <u>Dec 12</u> , 191 <u>0</u> , and that death occurred, on the date stated above, at <u>10a</u> m. The CAUSE OF DEATH* was as follows: <u>Cataract of Stomach</u> <u>1180</u>	
AGE <u>65</u> yrs. <u>10</u> mos. <u>5</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	(Duration) <u>2</u> yrs. ___ mos. ___ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Forming</u>			Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Province of Halstern Germany</u>			M. D. <input checked="" type="checkbox"/> (Address) <input checked="" type="checkbox"/>	
PARENTS	NAME OF FATHER <u>don't know</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. 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 _____	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Halstern Germany</u>			
	MAIDEN NAME OF MOTHER <u>Dorothy Kuhl</u>			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Halstern Germany</u>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nanni D. Mildeustrin</u> (ADDRESS) <u>Foley Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Corinth Cem</u>	
Filed <u>Dec 14</u> , 191 <u>0</u> <u>D D Deubar</u> REGISTRAR			DATE OF BURIAL <u>Dec 14</u> , 191 <u>0</u>	
			ADDRESS <u>Foley Mo</u>	

# 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*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sar-*

*coma*, 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 "Asthenia," "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.)



MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Lincoln  
Township \_\_\_\_\_  
or  
Village Foley Mo  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. 487 File No. 38664  
Primary Registration District No. 4294 Registered No. 17  
St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Nicholas Mildenstein

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

DATE OF BIRTH Feb 8, 1845  
(Month) (Day) (Year)

AGE 65 yrs 10 mos 5 ds. IF LESS than 1 day, hrs. or min.?

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

BIRTHPLACE Province of Holstein (Duration) 2 yrs. 0 mos. 0 ds.  
(City or town, State or foreign country) Germany

PARENTS NAME OF FATHER Don't know  
BIRTHPLACE OF FATHER Holstein Germany  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER Amachs Kuehl  
BIRTHPLACE OF MOTHER Holstein Germany  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) S. Mildenstein

(ADDRESS) Foley, Mo

Filed Dec 14 1910 DD Dumbas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 13, 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 12, 1910, to Dec 12, 1910, that I last saw him alive on Dec 12, 1910, and that death occurred, on the date stated above, at 10 a.m.  
The CAUSE OF DEATH\* was as follows:

Heartach of Stomach

Contributory (SECONDARY) (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) DD Dumbas M. D.  
Dec 14 1910 (Address) Foley Mo

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Green Cemetery DATE OF BURIAL Dec 14, 1910

UNDERTAKER G. A. Masterson ADDRESS Foley Mo.

DEC

All information called for must be written on this Supplementary Certificate.

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