

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH 14993		
County	<i>Henry</i>		Registration District No.	<i>248</i>	File No.
Township	<i>Crady</i>		Primary Registration District No.	<i>5480</i>	Registered No.
or					
Village					
or					
City		(NO. _____ St. _____ Ward _____)			(If death occurred in a hospital or institution, give its NAME instead of street and number)
FULL NAME <i>Unnamed</i>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <i>Female</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>single</i>	DATE OF DEATH <i>Dec - 29</i> , 191 <i>6</i> (Month) (Day) (Year)		
DATE OF BIRTH <i>Dec - 21</i> , 1911 (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <i>Dec - 29</i> , 1911, to <i>Dec 29</i> , 1911, that I last saw her alive on <i>Dec - 2</i> , 1911, and that death occurred, on the date stated above, at <i>9 P.</i> m. The CAUSE OF DEATH* was as follows: <i>Primary Cough</i>		
AGE _____ yrs. _____ mos. <i>9</i> ds.			If LESS than 1 day, _____ hrs. or _____ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <i>none</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>0</i>			109A <i>109A</i> <i>109A</i> (Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) <i>Henry Co Mo</i>			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <i>W. G. Shibley</i> M. D. <i>Dec 30</i> , 1911 (Address) <i>Bromfield Mo</i>		
PARENTS	NAME OF FATHER <i>Clarence R. Scher</i>		* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Henry Co Mo</i>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	MAIDEN NAME OF MOTHER <i>Arine F. Funch</i>		Where was disease contracted If not at place of death? Former or usual residence _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Mc Kays Co Mo</i>		PLACE OF BURIAL OR REMOVAL <i>Wagon</i> DATE OF BURIAL <i>12/30</i> 191 <i>6</i>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>W. G. Shibley</i> (ADDRESS) <i>Bromfield Mo</i>			UNDERTAKER <i>Wagon</i> ADDRESS _____		
Filed <i>Feb</i> 1 191 <i>6</i>			REGISTRAR <i>W. G. Shibley</i>		

# 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*, *peritonaemum*, 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.)



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.

PLACE OF DEATH

County Jerry  
 Township Osage  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 348 File No. 4993  
 Primary Registration District No. 5486 Registered No. 7

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

FULL NAME Unmaed Scheer

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Dec 21</u> , 19 <u>11</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>9</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Jerry Mo</u>		
PARENTS	NAME OF FATHER <u>Clarence P. Scheer</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	MAIDEN NAME OF MOTHER <u>Agnes French</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>De Kalb Co, Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 29, 1911  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 29, 1911, to Dec 29, 1911, that I last saw her alive on Dec 2, 1911, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 1 ds.

Contributory (SECONDARY) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) W. G. Strick M. D.  
Dec-30, 1911 (Address) Brownington Mo

\*State the Disease Causing Death, or, in deaths from Violent Cause, 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) W. G. Strick  
 (ADDRESS) Brownington

PLACE OF BURIAL OR REMOVAL <u>Wt Zion</u>	DATE OF BURIAL <u>12 30</u> , 19 <u>11</u>
UNDERTAKER <u>C. B. Rickett</u>	ADDRESS <u>Brownington Mo</u>

Filed Dec 30, 1911 by W. G. Strick REGISTRAR

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