

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 Franklin
County Franklin
Township _____ or _____
Village _____ or _____
City Washington (NO. _____ St. _____ Ward _____)
Registration District No. 297 File No. 25869
Primary Registration District No. 3016 Registered No. 38
FULL NAME Lillian Katherine Munch (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Infant</u> (Write the word)	DATE OF DEATH <u>Aug 22</u> , 191 <u>2</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Apr 26</u> — 19 <u>11</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>July 7</u> , 191 <u>2</u> , to <u>Aug 22</u> , 191 <u>2</u> , that I last saw her alive on <u>August 22</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>6 A. m.</u> The CAUSE OF DEATH* was as follows: <u>Cerebrospinal Meningitis</u>		
AGE <u>1</u> yrs. <u>3</u> mos. <u>26</u> ds. IF LESS than 1 day, _____ hrs. or _____ min.?			19 <u>12</u> 79 <u>04</u> (Duration) _____ yrs. <u>1</u> mos. <u>15</u> ds.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>do</u>			Contributory <input checked="" type="checkbox"/> (SECONDARY) (Duration) <u>X</u> yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>St. John's Twp. Mo.</u>			(Signed) <u>Joel D. Mansfield</u> M. D. <u>Aug 22</u> , 191 <u>2</u> (Address) <u>Washington Mo.</u>		
PARENTS	NAME OF FATHER <u>Geo. M. Munch</u>		*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) <u>St. John's Twp. Mo.</u>		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 <u>Bertha B. Hegon</u>		Where was disease contracted If not at place of death? Former or usual residence _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Jefferson City Mo.</u>		PLACE OF BURIAL OR REMOVAL <u>Odd Fellows Cemetery</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo. M. Munch</u> (ADDRESS) <u>Washington Mo.</u>			DATE OF BURIAL <u>Aug 24</u> , 191 <u>2</u> ADDRESS <u>Washington Mo.</u>		
Filed <u>Aug 22</u> , 191 <u>2</u> <u>O. L. Munch</u> REGISTRAR			UNDERTAKER <u>Henry Otto</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.)

HUGH STEPHENS, JEFFERSON CITY.



THIS IS A PERMANENT RECORD

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PLACE OF DEATH Franklin COUNTY Franklin REGISTRATION DISTRICT NO. 297 FILE NO. 25969

TOWNSHIP _____ OR VILLAGE _____ OR CITY Washington (NO. _____) ST. _____ WARD _____ REGISTERED NO. 39

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

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Infant
(Write the word)

DATE OF BIRTH Apr. 26, 1911 (Month) (Day) (Year)

AGE 1 yrs. 3 mos. 26 ds. If LESS than 1 day, hrs. or min.

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

BIRTHPLACE (City or town, State or foreign country) St. Johns Twp.

PARENTS
NAME OF FATHER Geo. M. Muench
BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Johns Twp.
MAIDEN NAME OF MOTHER Betha B. Heger
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jeffersonburg.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. M. Muench
(ADDRESS) Washington, Mo.

Filed Aug 22 1912 O. L. Muench REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 22, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 7, 1912, to Aug. 22, 1912, that I last saw her alive on Aug. 22, 1912, and that death occurred, on the date stated above, at 60 m.

The CAUSE OF DEATH* was as follows:
Cerebro spinal meningitis
caused by Diphtheria and Antitoxin
with high temperature
(Duration) _____ yrs. 1 mos. 15 ds.

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

(Signed) J. D. Manning M. D. (Address) Washington, 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 _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Odd Fellows Cem. DATE OF BURIAL Aug. 24, 1912

UNDERTAKER G. Henry Otto ADDRESS Washington Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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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 septichasmia," "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.)