

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

PLACE OF DEATH

County Linn
Township Baker
or
Village —
or
City — (NO. _____ St.: _____ Ward)

Registration District No. 506
Primary Registration District No. 5671

File No. 5946
Registered No. 1

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

FULL NAME Mathias Boland Schoch

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Single</u>
DATE OF BIRTH <u>January 19th 1913</u> (Month) (Day) (Year)		
AGE <u>7</u> yrs. <u>—</u> mos. <u>—</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>O-O</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Near Hybrid Baker Tp. Linn Co Mo</u>		
PARENTS	NAME OF FATHER <u>Claude W. Schoch</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Baker Tp. Linn Co. Mo</u>	
	MAIDEN NAME OF MOTHER <u>Winnie Moore</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Yellow Creek Tp Linn County Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 26th 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 19, 1913, to January 26, 1913, (that I last saw him alive on January 26, 1913, and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:
1st A Pneumonia

(Duration) ___ yrs. ___ mos. 2 ds.

Contributory Never did any good since born
I took no nourishment and secretions
Discharge
(Signed) J. S. Swans M.D.
January 26, 1913 (Address) Brookfield 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 New Garden Cemetery
DATE OF BURIAL Jan 27th 1913
UNDERTAKER M. Y. Ruck
ADDRESS Brookfield Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claude W. Schoch
(ADDRESS) St Catherine Mo
Filed Feb 1, 1913, J. B. Bond REGISTRAR

N. B. C. Careful! that it may be classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY.

Revised United State 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, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, 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 septichaemia," "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.)

PLACE OF DEATH

County LinnTownship Baker

Village _____

City _____ (NO. _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registration District No. 506

File No. _____

Primary Registration District No. 5671Registered No. 1

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

FULL NAME

Mathias Boland Schoch

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
DATE OF BIRTH <u>Jan 19</u> , 1913 (Month) (Day) (Year)		
AGE _____ yrs. <u>7</u> mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

PARENTS	NAME OF FATHER <u>Claude W. Schoch</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>
	MAIDEN NAME OF MOTHER <u>Margie Moon</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude W. Schoch(ADDRESS) St Catherine Mo.Filed Feb 1, 1913, J. B. Pound

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 26, 1913
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan 19, 1913, to Jan 26, 1913, that I last saw h. alive on Jan 26, 1913, and that death occurred, on the date stated above, at X m.

The CAUSE OF DEATH* was as follows:

meningitis Broncho
(Duration) _____ yrs. _____ mos. 2 ds.Contributory never did any good since born
(Secondary) took no medicine
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. B. Pound M. D.
3/8, 1913 (Address) Brookfield 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
New Garden Cem
DATE OF BURIAL
Jan 27, 1913
UNDERTAKER
M. Y. Rusk
ADDRESS
Brookfield Mo.Original file, date FEB, 1913

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

Every item of information should be checked. AGE should be carefully checked. SEX should be carefully checked. RACE should be carefully checked. OCCUPATION should be carefully checked. BIRTHPLACE should be carefully checked. PARENTS should be carefully checked. NAME OF FATHER should be carefully checked. BIRTHPLACE OF FATHER should be carefully checked. MAIDEN NAME OF MOTHER should be carefully checked. BIRTHPLACE OF MOTHER should be carefully checked. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE should be carefully checked. (Informant) should be carefully checked. (ADDRESS) should be carefully checked. Filed should be carefully checked. REGISTRAR should be carefully checked.

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 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.)

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