

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

7922

PLACE OF DEATH
County Levi
Township Jefferson
or
Village
or
City Jefferson (NO. _____ St.: _____ Ward)

Registration District No. 213 File No. _____
Primary Registration District No. 3014 Registered No. 54

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

FULL NAME Mrs Anna Crabf

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE 40 yrs. _____ 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 Mrs. Pohl BIRTHPLACE OF FATHER Germany MAIDEN NAME OF MOTHER Catherine Meyerpeter BIRTHPLACE OF MOTHER Mo.

THE (ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Walter Hysman (ADDRESS) Jefferson City, Mo.

Filed Mar. 19 1914 W. Bradford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 / 12, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 3-6, 1914, to 3-12, 1914, that I last saw her alive on 3-12, 1914, and that death occurred, on the date stated above, at 4:45 p. m.
The CAUSE OF DEATH* was as follows:

Sarcoma Ovary
49A
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. T. Charlton M. D. _____ 1914 (Address) _____

*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 St. Peter's Cemetery DATE OF BURIAL 3/19, 1914

UNDERTAKER Walter Hysman ADDRESS J. C. M.

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.

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, 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 *septicæmia*," "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, letanus*) 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.)

1—PLACE OF DEATH
COUNTY OF LOS ANGELES

STANDARD CERTIFICATE OF DEATH

District of

(No. *County Hospital* St. Ward) (If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

CITY OF LOS ANGELES

2—FULL NAME *Annie Crabb*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Female* 4 COLOR OR RACE *White* 5 ~~Single~~ ~~Married~~ ~~Widowed~~ ~~or Divorced~~ *Married*
(Write the word)

16 DATE OF DEATH *3-12-1914*
(Month) (Day) (Year)

6 DATE OF BIRTH
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from *3-6-1914* to *3-12-1914*

7 AGE *50* years.....mos.....ds. If less than 1 day.....h. or.....min.!

that I last saw her alive on *3-12-1914* and that death occurred on the date stated above at *4:45 p.m.*

8 OCCUPATION (a) Trade, profession or particular kind of work. *house work* (b) General nature of industry business, or establishment in which employed (or employed)

The CAUSE OF DEATH* was as follows:

Sarcoma Vary

9 BIRTHPLACE (State or County)

10 NAME OF FATHER *Jno Pohl*

11 BIRTHPLACE OF FATHER (State or County) *Germany*

12 MAIDEN NAME OF MOTHER *Catherine Meyerpeter*

13 BIRTH PLACE OF MOTHER (State or County) *Mary*

13a LENGTH OF RESIDENCE

At Place of Death.....years.....months.

In California.....years.....months.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Co J Hosp*

(Address) *1100 Mission Road*

15 Filed.....191..... Subregistrars

Filed.....191..... Registrars or Deputy

(Duration).....yrs.....mos.....ds.

Contributory (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *D. T. Charleston* M. D.

191..... (Address)

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

18 SPECIAL INFORMATION only for Hospitals, Institutions, Transients or Recent Residents

Former or Usual Residence *449 Procker* How long at Usual Residence..... Place of death..... Days

Where was disease contracted If not at place of death.....

19 PLACE OF BURIAL OR REMOVAL *Jefferson City Mo* DATE OF BURIAL *3-15-14*

20 UNDERTAKER *H. C. Draper Co.,* ADDRESS *1142 S. Los Angeles St.*

See instructions on back of certificate. N. B. Physicians should state CAUSE OF DEATH in plain terms, that it may properly classified. Exact statement of OCCUPATION is very important.