

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

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City \_\_\_\_\_  
 Registration District No. 1003 File No. 17264  
 Primary-Registration District No. \_\_\_\_\_ Registered No. 4423  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

**FULL NAME** Infant of Wm. and Anna Koehmann

**PERSONAL AND STATISTICAL PARTICULARS**

**SEX** Male **COLOR OR RACE** White **SINGLE MARRIED WIDOWED OR DIVORCED** Single  
 (Write the word)  
**DATE OF BIRTH** April 30<sup>th</sup> 1914  
 (Month) (Day) (Year)  
**AGE** \_\_\_\_\_ If LESS than 1 day, 2 hrs. or 5 min.?  
 yrs. mos. ds.  
**OCCUPATION**  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH** April 30, 1914  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from April 30, 1914, to April 30, 1914, that I last saw him alive on April 30, 1914, and that death occurred, on the date stated above, at 10 A.M.  
 The CAUSE OF DEATH\* was as follows:  
Premature Birth.  
159 (Duration) yrs. mos. ds.  
151 (Duration) yrs. mos. ds.

**BIRTHPLACE**  
 (City or town, State or foreign country) St. Louis

**PARENTS**  
**NAME OF FATHER** Wm. Koehmann  
**BIRTHPLACE OF FATHER**  
 (City or town, State or foreign country) St. Louis  
**MAIDEN NAME OF MOTHER** Anna Brockheldt  
**BIRTHPLACE OF MOTHER**  
 (City or town, State or foreign country) St. Louis

**Contributory** as above  
 (Secondary)  
 (Duration) yrs. mos. ds.  
 (Signed) C. E. Aldenderfer M. D.  
Apr 30, 1914 (Address) 2407 Wren  
 \*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Wm. Koertmann  
 (ADDRESS) 8368 Schulte Ave.

**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 \_\_\_\_\_

Filed 1914-4-30 Mark Starkley REGISTRAR

**PLACE OF BURIAL OR REMOVAL** St. Peters Cemetery **DATE OF BURIAL** May 1, 1914  
**UNDERTAKER** L. Bochner **ADDRESS** 4438 N. 9th St.

and e. ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo...  
 PHYSICIANS should be stated EXACTLY.

# 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, peritoneum*, 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 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.)

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_  
or  
Village St. Louis  
or  
City \_\_\_\_\_

Registration District No. 791

File No. 17264

Primary Registration District No. 1003

Registered No. 4423

FULL NAME Unnaued Wehrmann

(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 M COLOR OR RACE W SINGLE S MARRIED S WIDOWED S OR DIVORCED S  
(Write the word)

DATE OF DEATH \_\_\_\_\_, 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw him \_\_\_\_\_, 191\_\_\_\_,  
and that death occurred, on the \_\_\_\_\_, 191\_\_\_\_,  
at \_\_\_\_\_.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

THE CAUSE OF DEATH\* was as follows:  
\_\_\_\_\_

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 Wehrmann  
BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
MAIDEN NAME OF MOTHER \_\_\_\_\_  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wehrmann  
(ADDRESS) 8368 Schulte Ave

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

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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Filed Oct 13 1914 191\_\_\_\_ U. S. Snodgrass REGISTRAR

Every item of information should be stated EXACTLY. PHYSICIANS should be properly signed. Exact statement of OCCUPATION is required.

SUPPLEMENTARY Satisfactory Information Supplied.

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