

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

PLACE OF DEATH

County _____

Township _____

or Village _____

or City _____

Registration District No. 791

Primary Registration District No. 1003

File No. 27690

Registered No. 7717

City St. Louis (NO Josephine Hospital St. 16 Ward)

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

FULL NAME Antonina Winter

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF DEATH Aug 13th
(Month) (Day) (Year) 1914

DATE OF BIRTH March 2, 1868
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 9th, 1914, to Aug 13th, 1914,

AGE 46 yrs. 5 mos. 12 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

that I last saw her alive on Aug 13th, 1914, and that death occurred, on the date stated above, at 4 P.M.

OCCUPATION (a) Trade, profession, or particular kind of work Housework 142 B
(b) General nature of industry, business, or establishment in which employed (or employer) 142 B

The CAUSE OF DEATH* was as follows:
Extra uterine Gestation

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

(Duration) ____ yrs. 2 mos. ____ ds.
Contributory Hemorrhage & Shock
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

NAME OF FATHER Adolph Schmalenberg

(Signed) [Signature] M. D.
Aug 14th, 1914 (Address) 1632 S. Franklin

BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany

MAIDEN NAME OF MOTHER Mrs Mary Schmalenberg

*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 MOTHER (City or town, State or foreign country) Germany

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. 4 ds. In the State 35 yrs. ____ mos. ____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Winter

Where was disease contracted if not at place of death? Residence
Former or usual residence St. James Mo

(ADDRESS) St. James Mo

PLACE OF BURIAL OR REMOVAL St. James Mo DATE OF BURIAL Aug. 14th 1914

Filed 21 BY Max Starkloff REGISTRAR

UNDERTAKER Bloember of Louis ADDRESS 3163 S. Grand

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*, *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*, *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

County _____

Township _____

or _____

Village _____

or _____

City _____ (NO. _____)

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 191

File No. _____

Primary Registration District No. 1003Registered No. 7717

St. _____ Ward _____

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

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OF FACE N. SINGLE MARRIED WIDOWED OR DIVORCED M.
(Write the word)DATE OF BIRTH _____
(Month) (Day) (Year)AGE _____
IF LESS than _____ day _____ hr _____ min _____
_____ yrs. _____ mos. _____ ds.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) _____

NAME OF FATHER _____

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) _____

(ADDRESS) _____

Signed _____ 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 13, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____, 191____,

and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH was as follows:Extra Uterine Gestation
Shock due to rupture of Fallopian tube
(Duration) _____ yrs. _____ mos. _____ ds.Contributory Hemorrhage & Shock
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.(Signed) F. J. [Signature] M. D.
8/14, 1914 (Address) 30 S. Grand

*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 _____

Original file, date AUG 1914, 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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