

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

PLACE OF DEATH

County Marion

Township _____
or _____

Village _____
or _____

City Hannibal (NO. _____)

Registration District No. 547

File No. 1746

Primary Registration District No. 3029

Registered No. 18

St. 6 Ward _____

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

FULL NAME Dorthea C. Schnellmann

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE Single
MARRIED WIDOWED OR DIVORCED
(If write the word)

DATE OF DEATH January 29, 1915
(Month) (Day) (Year)

DATE OF BIRTH Jan 6, 1886
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 25, 1915, to January 29, 1915,

AGE 1 yrs. 23 ds. If LESS than 1 day, ___ hrs. or ___ min.?

that I last saw her alive on January 27, 1915, and that death occurred, on the date stated above, at 3:25 am.

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

The CAUSE OF DEATH* was as follows:
Tuberculosis

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

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

(Duration) _____ yrs. 18 mos. _____ ds.

NAME OF FATHER Joseph Schnellmann

Contributory (SECONDARY) _____

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

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

MAIDEN NAME OF MOTHER Verina Campbell

(Signed) Johes H Williams M. D.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Louisiana Mo

(Address) Bakwood Mo

* 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) W E Campbell

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 _____

(ADDRESS) Hannibal Mo

PLACE OF BURIAL OR REMOVAL Hidsburg cemetery DATE OF BURIAL Jan 30, 1915

Filed Jan 30, 1915 W W Young REGISTRAR

UNDERTAKER Osamey B ADDRESS Hannibal

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) *Colton 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.)

County Marion

Township _____

Registration District No. 547

File No. _____

Village _____

Primary Registration District No. 3029

Registered No. 18

City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Antha E. Schullman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH June 29, 1921
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, _____
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day, _____ hrs. or _____ min.

Supplied. 3 21
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) _____

Pneumonia
Branch
(Duration) _____ yr _____ mos _____ ds.

BIRTHPLACE
City or town, _____
State or foreign country _____

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

NAME OF FATHER _____

(Signed) Dr. John W. Williams M.D.
June 29, 1921 (Address) _____

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

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

MAIDEN NAME OF MOTHER _____

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

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

Where was disease contracted if not at place of death? _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Former or usual residence _____

(Informant) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

(ADDRESS) _____

UNDERTAKER _____ ADDRESS _____

Filed 1/30 1921 W. H. Yause REGISTRAR

N. B.—Every item of information should be carefully and fully classified. Exact statement of OCCUPATION is particularly important. Cause of DEATH in plain terms, so that it may be p.

Original file, date June 15, 1921 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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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*" ("*Con- genital*," "*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.)