

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

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

Registration District No. 806 File No. 11194
Primary Registration District No. 6057 Registered No. 5

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

FULL NAME Nathan Sinnerel

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED widower
(Write the word)

DATE OF BIRTH Mich 22, 1873
(Month) (Day) (Year)

AGE 81 yrs. 11 mos. 13 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

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

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

NAME OF FATHER Don't know

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

MAIDEN NAME OF MOTHER Don't know

BIRTHPLACE OF MOTHER Don't know
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Kuth

(ADDRESS) Queen City, Mo

Filed Mar 6, 1915 W. H. Jickel
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mich. 5, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 10, 1914, to Mar 5, 1915, that I last saw him alive on Mar 2, 1915,

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Exhaust from a fractured hip or fracture of neck of femur.

1948 (Duration) yrs. 6 mos. ds.

1068 Chronic bronchitis
(SECONDARY) a good many years
(Duration) yrs. mos. ds.

(Signed) W. H. Jickel M. D.

Mar 6, 1915 (Address) Queen City, 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 Woffey lawn DATE OF BURIAL Mich, 1915

UNDERTAKER W. H. Biggs ADDRESS Queen City, Mo

N. B.—Every item on this form should be filled. AGE should be filled. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease.

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, 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 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.)

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

PLACE OF DEATH

County Shuylar
 Township Franklin
 Village _____
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 806 File No. _____
 Primary Registration District No. 6051 Registered No. 51

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

FULL NAME Nathan Simerel

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, 1917
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1917 to _____, 1915, that I last saw him alive on _____, 1915, and that death occurred, on the date stated above, at 5 P.M.

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

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) _____

Support from a fractured hip or fracture of neck of femur? accidental.

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

Contributory Chronic Bronchitis (Secondary) old good many years. (Duration) _____ yrs. _____ mos. _____ ds. (Signed) W. H. Fisher M. D. 376 (Address) Queen City

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) _____

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1915

Filed 3/5 1915 W. H. Fisher REGISTRAR

UNDERTAKER _____ ADDRESS _____

This page should be carefully examined by the physician to see that it is properly classified. It should be returned to the registrar.

Satisfactory information supplied. SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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