

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

1 PLACE OF DEATH

County Buchanan

Township _____
or _____

Registration District No. 85

File No. 4726

Village _____
or _____

Primary Registration District No. 1001

Registered No. 245-

City St Joseph (NO Brewer's Hoop St. _____)

Ward _____

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

2 FULL NAME Mary Whrli

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OF RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Febr 1 866
(Month) (Day) (Year)

7 AGE 51 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife 5718
(b) General nature of industry business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (City or town, State or foreign country) Ill

10 NAME OF FATHER Peter Streep

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

12 MAIDEN NAME OF MOTHER unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Rock

(Address) 916 Fred Ave

15 Filed April 23, 1917 Dostreey
Registrar

4 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 21 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 8, 1917, to Feb 21, 1917, that I last saw him alive on Feb 21, 1917, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Toxemia

(Duration) _____ yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Hypertension

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

(Signed) Ch. Wallace M. D. 2-21, 1917. (Address) 301 No 8th St.

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. 14 ds. In the unknown State _____ yrs. _____ mos. _____ ds.

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

Former or usual residence. Third City Mo

19 PLACE OF BURIAL OR REMOVAL Mound. City Mo DATE OF BURIAL Feb 23, 1917

20 UNDERTAKER Rock ADDRESS 916 Fred Ave

Revised United States Standard Certificate of Death

[Approved by U. S. Consus 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.)

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

County
 Township Registration District No. 85 File No. 4726
 or
 Village Primary Registration District No. 1004 Registered No. 245
 or
 City Joseph (NO Eusworth Hosp St. Ward) (If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number.)

2 FULL NAME Mary Wehli

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M

16 DATE OF DEATH 10-21-1917
 (Month) (Day) (Year)

6 DATE OF BIRTH 1
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....

7 AGE yrs. mos. da. If LESS than 1 day, hrs. or min.?

that I last saw him alive on 191.....
 and that death occurred, on the date stated above at m.

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

The CAUSE OF DEATH* was as follows:

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

Suppurative lymphadenitis
Septic pleuritis

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

Duration yrs. mos. ds.

10 NAME OF FATHER

CONTRIBUTORY (Secondary) Subacute fibroma

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

Duration yrs. mos. ds.

12 MAIDEN NAME OF MOTHER

Signed J. H. Hall M. D.

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

R-5, 1918 (Address) 701. N. 8th St. Joseph Mo

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Informant)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Address)

Where was disease contracted if not at place of death?

Former or usual residence

15

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....

Filed 191.....

20 UNDERTAKER ADDRESS

Registrar

Original file, date....., 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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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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *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.)