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.

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

24903

1 PLACE OF DEATH

County Franklin

Township Union

or

Village

or

City ~~Union~~ (NO. ..... St. ..... Ward)

Registration District No. 296 File No. .....

Primary Registration District No. 5413 Registered No. .....

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

2 FULL NAME Julia Marie Sophie Zehrt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH Oct (Month) 26 (Day) 1882 (Year)

7 AGE 34 yrs. 8 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer) ——

9 BIRTHPLACE (City or town, State or foreign country) Washington Mo.

PARENTS

10 NAME OF FATHER Fred Hackenjose

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

12 MAIDEN NAME OF MOTHER Julie Jacobsen

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Julie Jacobsen

(Address) St. Louis Mo.

15 Filed July 23, 1917, E A Steinberger Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 21st (Day), 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 18, 1917, to July 21st, 1917, that I last saw her alive on July 20, 1917, and that death occurred, on the date stated above, at 2:15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

820 64

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

CONTRIBUTORY (Secondary) .....

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

(Signed) E A Steinberger M. D.

July 23, 1917 (Address) Union Mo

*State the Disease Causing Death, or, in deaths 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. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Union Cemetery

DATE OF BURIAL July 23, 1917

20 UNDERTAKER W H Horn

ADDRESS Union Mo

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, 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," "(lsions," "Debility" ("C ropsy," "Exhaustion," rhage," "Inanition," " Shock," "Uraemia," " definite disease can be Always qualify all disea or mis- carriage, as "Pu RPERAL *peritonitis,*" etc. l oper- ation was und s state MEANS OF INJU , SUI- CIDAL, OR HOMI impos- sible to determi *idental drowning; Struck* *evolver wound of head—* *acid—* *probably suicide* y, as fracture of skul *sepsis,* *tetanus*) may be "Con- tributory." (Re t of cause of death a bmen- clature of the A

County

Missouri