

D. *Hermitage*
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8323

1. PLACE OF DEATH

County Greene Registration District No. 2091 File No. 232
 Town Springfield Mo Primary Registration District No. 2091 Registered No. 232
 City Springfield Mo No. Farmer Ave. St. Ward

2. FULL NAME

(a) Residence No. Farmer Ave. St. Ward
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Miss Schuchow</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 5 1886</u>		
7. AGE <u>36</u>	YEARS <u>4</u>	MONTHS <u>22</u> DAYS <u> </u> If LESS than 1 day, <u> </u> hrs. or <u> </u> min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Teacher</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> (c) Name of employer <u> </u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-27 1922
 17. I HEREBY CERTIFY, That I attended deceased from , 1922, to 3-26-22 that I last saw him alive on 3-26-22 and that death occurred, on the date stated above, at 12:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia on
11 P. night
 (duration) yrs. mos. 4 ds.
 CONTRIBUTORY (SECONDARY) Cholerae
 (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
Mo.
 IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? General aut
done by
 (Signed) W. H. Pennington, M. D.
 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in cases from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greene DATE OF BURIAL 3/29 22
 20. UNDERTAKER W. H. Pennington ADDRESS Market

PARENTS	10. NAME OF FATHER <u>Mo. August Engleking</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
	12. MAIDEN NAME OF MOTHER <u>Lea M. Engleking</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Germany</u>
14. INFORMANT <u>Mrs. Paul Engleking</u> (Address) <u>Farmer Ave.</u>	
15. <u>W. H. Pennington</u> REGISTRAR	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

FILED 29 1922
W. H. Pennington
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question applies to each and every person, irrespec-
tion 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*, *Locomo-
tive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc.
But in many cases, especially in industrial employ-
ments, 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) *Sales-
man*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile fac-
tory*. The material worked on may form part of the
second statement. Never return "Laborer," "Fore-
man," "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 occu-
pation at beginning of illness. If retired from busi-
ness, that fact may be indicated thus: *Farmer (re-
tired, 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

monia"); *Lobar pneumonia*; *Broncho-
neumonia*, unqualified, is indefinite);
lungs, *meninges*, *peritoneum*, etc.,
coma, etc., of (name ori-
is less definite; avoid use of "Tumor"
eplasma); *Measles*; *Whooping cough*;
heart disease; *Chronic interstitial*
The contributory (secondary or in-
jection need not be stated unless im-
ple: *Measles* (disease causing death),
chopneumonia (secondary), 10 ds.

Never report mere symptoms or terminal conditions,
such as "Asthenia," "Anemia" (merely symptom-
atic), "Atrophy," "Collapse," "Coma," "Convul-
sions," "Debility" ("Congenital," "Senile," etc.).
"Dropsy," "Exhaustion," "Heart failure," "Hem-
orrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uremia," "Weakness," etc., when a
definite disease can be ascertained as the cause.
Always qualify all diseases resulting from child-
birth or miscarriage, as "PUERPERAL *septicemia*,"
"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 rail-
way 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.)

NOTE.—Individual offices may add to above list of undesi-
rable terms and refuse to accept certificates containing them.
Thus the form in use in New York City states: "Certificates
will be returned for additional information which give any of
the following diseases, without explanation, as the sole cause
of death: Abortion, cellulitis, childbirth, convulsions, hemor-
rhage, gangrene, gastritis, erysipelas, meningitis, miscarriage,
necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus."
But general adoption of the minimum list suggested will work
vast improvement, and its scope can be extended at a later
date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.