

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

11559

1. PLACE OF DEATH

County Schenley
Township Jabilus
City..... (No.....)..... (Ward.....)

Registration District No. P02
Primary Registration District No. 6046

File No.....
Registered No.....

2. FULL NAME

Daniel Gingerich

(a) Residence. No..... Ward..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male | White | Married

6. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF

Barbara Gingerich

7. DATE OF BIRTH (MONTH, DAY AND YEAR)

Apr 25 1838

8. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.

84 | 11 | 1

9. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

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

(c) Name of employer.....

10. BIRTHPLACE (CITY OR TOWN)

Baden

(STATE OR COUNTRY)

Ontario Canada

11. NAME OF FATHER

Peter Gingerich

12. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

13. MAIDEN NAME OF MOTHER

Magdalena Miller

14. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

PARENTS

15. INFORMANT (Address)

Carrie Brubaker
Lancaster Mo.

FILED 3-27 1923

J. B. Bond
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

3-26 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1923 to Jan 22 1923 that I last saw him alive on Jan 23 1923 and that death occurred, on the date stated above, at 7 10 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral Hemorrhage
Paralysis
(duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY)

(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) H. E. Gerwig, M. D.
, 19 (Address) Lancaster Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Darby Cemetery

Mar 28 1923

20. UNDERTAKER

ADDRESS

John A. Roberts
Lancaster 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*, *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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth 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 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.)

NOTE.—Individual offices may add to above list of undesirable 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, hemorrhage, 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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Schuyler State MISSOURI. 802 Registered No. _____
 Township Palms or Village 6046 or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniel Ginzgerich
 (a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident give city or town and State)
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 <small>(write the word)</small> <u>m</u>	
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____			
6 DATE OF BIRTH (month, day, and year) _____			
7 AGE	Years _____	Months _____	Days _____
8 OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____			
9 BIRTHPLACE (city or town) _____ (State or country) _____			
PARENTS	10 NAME OF FATHER _____		
	11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____		
	12 MAIDEN NAME OF MOTHER _____		
	13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____		
14 Informant _____ (Address) _____			
15 Filed <u>3-27, 1923</u> <u>J. B. Budge</u> REGISTRAR			

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) <u>Mar 26 1923</u>
HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows: <u>Paralysis</u> <u>of the Cerebral</u> <u>Membrane</u> (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
18 Where was disease contracted _____ If not at place of death? _____
Did an operation precede death? _____ Date of _____
Was there an autopsy? _____
What test confirmed diagnosis? _____
(Signed) _____, M. D. _____, 19 (Address) _____
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19 PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____
20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

INFORMATION is very important. See instructions on back of certificate.

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BY PHYSICIAN.

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