

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

4653

24 1927

**1. PLACE OF DEATH**

County Jackson Registration District No. 396 File No. 1  
 Township Fort Osage Primary Registration District No. 552 Registered No. 3  
 City Buckner Mo. (No. ....) St. .... Ward)

**2. FULL NAME**

Minnie Mabel Schneider  
 (a) Residence. No. Adessa Mo. - St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fred Schneider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 21 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
36 8 21

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work General house work  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (CITY OR TOWN) Buckner Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER Uriah Myers

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Monroe Ohio  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Phoebe Thatcher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dogleten Ind.  
 (STATE OR COUNTRY)

14. INFORMANT Mrs. P. W. Knaphide  
 (Address) Buckner, Mo.

15. FILED 3-10, 1927 N. D. Bancroft  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1927 to Feb. 12 1927.  
 that I last saw him alive on Feb. 11 1927, and that death occurred, on the date stated above, at 6 A. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

155 Encephalitis  
1927 (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 .....

18 WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) N. D. Bancroft, M. D.  
3-10 1927 (Address) Buckner 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 Buckner, Missouri DATE OF BURIAL Feb. 14 1927

20. UNDERTAKER Vernon M. Rappert ADDRESS Buckner

N. B.—Every item of information should be carefully checked. 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.

# 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; Broncho-pneumonia* ("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 neoplasm); *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.; *Broncho-pneumonia* (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," "Infantion," "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.

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Jackson Registration District No. 396 File No. \_\_\_\_\_  
 Township Osage Primary Registration District No. 5552 Registered No. 3  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

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

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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**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) \_\_\_\_\_

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 \_\_\_\_\_ 19 \_\_\_\_\_ N.S. Mansueti  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12 1927

17. I 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:

Cerebral  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY Slight laceration on chest  
 (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) \_\_\_\_\_

\*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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

N. B. - Every item of information on CAUSE OF DEATH in plain terms, REGISTRARS SHALL NOT RECEIVE FOR INFORMATION. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

5-4653

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ated by check marks, lacking in the death certificate:

Name: Nannie Mabel Schneider

Who died at: Jackson Co. on Feb. 12, 1927.

Residence: No. \_\_\_\_\_ St. Adasa Mo.  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: Female Color or race: White Single, married, widowed or divorced: Married

Date of birth: May. 21-1890 Age: Years 36 Months 8 Days 20

Occupation: (a) Trade Housewife (b) Industry: \_\_\_\_\_

Birthplace (State or country) Jackson Co. Mo.

Birthplace of father (State or country) Ohio

Birthplace of mother (State or country) Indiana

CAUSE OF DEATH: Erysipelas 2/B

Contributory: Slight laceration on cheek  
Caused by metal hair pin

Where was disease contracted? Adasa Mo.

Did operation precede death? No Date of \_\_\_\_\_

Was there an autopsy? No What test confirmed diagnosis? Clinical

Name of physician: No Record

Address of physician: Buckner Mo.

(52)-4653