

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

34472

1 PLACE OF DEATH

County St. Charles
Township D. Fallon
or
Village O'Fallon
or
City (NO. St. Ward)

Registration District No. 760 File No. ✓
Primary Registration District No. 6001 Registered No. 45

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

2 FULL NAME Sister Rosalia Schleiniger

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>7</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>November 10 1927</u> (Month) (Day) (Year)		
7 AGE <u>80</u> yrs. <u>12</u> mos. <u>12</u> ds.		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Teacher</u> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Baden</u>		
PARENTS	10 NAME OF FATHER <u>Mr. Schleiniger</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Baden</u>	
	12 MAIDEN NAME OF MOTHER	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Baden</u>	

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 22 27
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 30, 1920 to Nov 22, 1927 that I last saw her alive on Nov 21, 1927 and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:
Ataxia Paralytica
8 1/2 yrs. Indefinite
(Duration) (yrs.) (mos.) (ds.)

CONTRIBUTORY (Secondary)
✓
(Signed) R. N. Rosemeyer M. D.
Nov 23, 1927 (Address) O'Fallon 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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sr. M. Hernandez
(Address) O'Fallon Mo.

19 PLACE OF BURIAL OR REMOVAL O'Fallon Mo. DATE OF BURIAL....., 191.....

15 Filed 11-24- 1927 J. M. Jenkins Registrar

20 UNDERTAKER Mr. Keithley ADDRESS.....

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.

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," "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.)

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Charles Registration District No. 450 File No. _____
 Township Dardennae Primary Registration District No. 6001 Registered No. 43-
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME Sister Rosalia Schleiniger
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

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 Don't know

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

14. INFORMANT _____ (Address) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ after on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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) _____, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL O'Fallon, Mo. DATE OF BURIAL Nov 24 1927

20. UNDERTAKER Mr. Keithly ADDRESS O'Fallon, Mo.

SUPPLEMENTARY

15. FILED 11-24 1927 J.M. Jenkins REGISTRAR

N. B.—For information—3 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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