

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

PLACE OF DEATH

Morgan
Morrow
Country

Registration District No. 578

File No. 36911

Primary Registration District No. 5792B

Registered No. 34

FULL NAME

Caroline Aeschbacher

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male Female
 COLOR OR RACE white
 SINGLE MARRIED Widowed WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH June 26, 1851
 (Month) (Day) (Year)
 61 yrs. 47 mos. 28 ds.
 IF LESS than 1 day, hrs. or min.?

DATE OF DEATH Nov 24, 1913
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Sep 12, 1913 to Nov 23, 1913, that I last saw her alive on Nov 23, 1913, and that death occurred, on the date stated above, at K.P.C. m.

OCCUPATION Housewife
 Trade, profession, or particular kind of work
 General nature of industry, business, or establishment in which employed (or employer)

THE CAUSE OF DEATH* was as follows:
 50 Cancer
 415

BIRTHPLACE Wayne, Ohio
 (City or town, State or foreign country)

(Duration) 2 yrs. 3 mos. ds.

NAME OF FATHER John Garber

Contributory (SECONDARY)
 (Duration) 2 yrs. 3 mos. ds.

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

(Signed) H.E. Blacksten M. D.
 (Address) Excelsior

MAIDEN NAME OF MOTHER Barbara Loganbill

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER Switzerland
 (City or town, State or foreign country)

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 Informant) C. Aeschbacher

Where was disease contracted If not at place of death?
 Former or usual residence

(ADDRESS) Excelsior

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
 Bethel Church Nov 26, 1913

Filed Nov 25, 1913 H.N. Lutman REGISTRAR

UNDERTAKER ADDRESS
 W.B. Kidwell Versailles

Group - 1: Typhoid pneumonia; Lobar pneumonia; Bronchopneumonia ("Pneumonia"); unqualified, is indefinite); Tuberculosis of lungs.

SENTS

PLACE OF DEATH

MISSOURI STATE BOARD OF
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____ Registration District No. _____ File No. _____
 Township _____ Primary Registration District No. _____ Registered No. _____
 or Village _____
 or City _____ (NO. _____ St. _____ Ward _____) (If death
 hospital
 give
 of street

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____, 191____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
 (City or town, State or foreign country) _____
 NAME OF FATHER _____
 BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____
 MAIDEN NAME OF MOTHER _____
 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (informant) _____
 (ADDRESS) _____

MEDICAL CERTIFICATE OF DATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____
 I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____, 191____, that I last saw him _____ alive on _____ and that death occurred, on the date state above, at _____
 The CAUSE OF DEATH was as follows: follows: _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos.
 (Signed) _____ (Duration) _____ yrs. _____ mos.
 _____ (Address) _____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, State _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Former or usual residence. _____
 Where was disease contracted if not at place of death? _____
 Former or usual residence. _____

PLACE OF BURIAL OR REMOVAL DA DATE OF BURIAL
 UNDERTAKER ADI ADDRESS

Filed _____, 191____ REGISTRAR

10
20721
County
Township
or
Village
or
City
11
12

PLACE OF DEATH
Morgan

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. *598* File No. _____
Primary Registration District No. *5792B* Registered No. *24*

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

FULL NAME *Caroline Aeschbacher*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *F* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED *W*
(Write the word)

DATE OF DEATH *11-24*, 191*3*
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Sept 15*, 191*3*, to *11-23*, 191*3*
that I last saw her alive on *11-23*, 191*3*
and that death occurred, on the date stated above, at *11:30* a.m.

AGE _____
If LESS than 1 day, ___ hrs. or ___ min.
yrs. mos. ds.

The CAUSE OF DEATH* was as follows:
Cancer originating in breast primary affecting the liver.

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

(Duration) *2* yrs. *3* mos. ds.

BIRTHPLACE (City or town, State or foreign country) _____

Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ds.
Signed *A. E. Blacksten* M.D.
(Address) *C. Celesior*

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT-RESIDENTS)

At place of death ___ yrs. ___ mos. ds. In the State ___ yrs. ___ mos. ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(Informant) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191*3*

(ADDRESS) _____

Filed *11-25* 191*3* *A. E. Blacksten* REGISTRAR

UNDERTAKER _____ ADDRESS _____

Be-Each item of information should be carefully supplied. A fee shall be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Associated

Satisfactory Information Supplied.
 SUPPLEMENTARY
 Satisfactory Information Supplied.

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.)

113