

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

PLACE OF DEATH
County Mountain
Township Walker
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 571 File No. 65461
Primary Registration District No. 6769 Registered No. 15

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

FULL NAME Mrs Anna L Rohrbach

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White MARRIED Married
WIDOWED
OR
SEPARATED
(Write the word)

DATE OF DEATH February 25, 1915
(Month) (Day) (Year)

DATE OF BIRTH March 28, 1876
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 20th, 1915, to Feb. 25, 1915, that I last saw her alive on Feb 25, 1915, and that death occurred, on the date stated above, at 4:57 m.

AGE 38 10 27
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:
Nephritis
Albuminuria
131
(Duration) _____ yrs. _____ mos. _____ ds.

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

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. M. [Signature] M. D.
2/27, 1915 (Address) California Mo

BIRTHPLACE (City or town, State or foreign country) Mountain County

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

PARENTS
NAME OF FATHER Mr Fred Block
BIRTHPLACE OF FATHER (City or town, State or foreign country) Switzerland
MAIDEN NAME OF MOTHER Mrs Block
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Switzerland

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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Rohrbach
California
(ADDRESS)

PLACE OF BURIAL OR REMOVAL Rohrbach Cemetery DATE OF BURIAL 2/27, 1915
UNDERTAKER Edw. Kischutz ADDRESS California

Filed 2 27, 1915 H. R. Pappas, MD REGISTRAR

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*, *letanus*) 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.)

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Monteure
Township Walker
or
Village
or
City

Registration District No. 571 File No. _____
Primary Registration District No. 5769 Registered No. 15

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

FULL NAME Anna L. Rohrbach

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____
(Month) (Day) (Year)
IF LESS than 1 day, _____ hrs or _____ min
_____ yrs _____ mos _____ ds.

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)

PARENTS
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)
Filed 7/27 1918 S. H. R. Pappas M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb - 25, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Nephritis
Chronic
Albuminuria
(Duration) _____ yrs _____ mos _____ ds.

Contributory Albuminuria
(SECONDARY) (Duration) _____ yrs _____ mos _____ ds.
(Signed) S. H. R. Pappas M.D.
7/27 (Address) Californ

*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. State _____ yrs _____ mos _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1918

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION Supplied

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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