

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

PLACE OF DEATH

County Dunk

Township Norman

Village _____

City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 269

File No. 28890

Primary Registration District No. 5376

Registered No. 4

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

FULL NAME Lidona Kruger

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) ✓

DATE OF BIRTH Sep. 19, 1837
(Month) (Day) (Year)

AGE 76 10 23 If LESS than 1 day, ___ hrs. or ___ min.?
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) _____

BIRTHPLACE (City or town, State or foreign country) Saxweissen Germany

NAME OF FATHER Gottfried Haas

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

MAIDEN NAME OF MOTHER Christina March

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Autzisa Brach Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Wm. A. Kruger

(ADDRESS) Salem Mo.

Filed Sep. 9, 1914 Wilson M. Lenix REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 12, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sep. 1910 to Jan. 1914, that I last saw her alive on Aug. 1st, 1913,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

137 1/2 Leuk Droopy

903
102 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wilson M. Lenix M. D. Aug 9, 1914 (Address) Robson Mo.

*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.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Norman Cemetery DATE OF BURIAL Aug 14, 1914

UNDERTAKER Hollie Ashen ADDRESS Salem 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) *Colton 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 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 *septicæmia*," "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.)

N. B.—Person of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly understood. A FEE is not charged for this certificate.

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

PLACE OF DEATH
 County Leuven
 Township Norman
 or
 Village
 or
 City

Registration District No. 269 File No. _____
 Primary Registration District No. 5376 Registered No. 4
 (No.) _____ St.: _____ Ward _____

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

FULL NAME Edona Kruger

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 12, 1914
 (Month) (Day) (Year)

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

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

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

The CAUSE OF DEATH* was as follows:

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

Heart Disease
Brugada Disease
the Krugers
 (Duration) 3 yrs. 170 mos. 170 ds.
 Contributory (SECONDARY) Septicemia Aug 17
General Dropsy
 (Duration) 1 yrs. _____ mos. _____ ds.

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) _____

(Address) _____, 1914 (Address) _____
 *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 Informant) _____

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 _____

(ADDRESS) _____
 _____, 1914
 REGISTRAR _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

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