

PLACE OF DEATH

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

County _____

Township _____

Registration District No. 791File No. 25500

Village _____

Primary Registration District No. 1003Registered No. 6261City St. Louis (NO. 38199 Hudson Pl St. 25 Ward)

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

FULL NAME Alvina Schubert

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)DATE OF DEATH August 11th, 1910
(Month) (Day) (Year)DATE OF BIRTH Dec 22, 1908
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from July 25th, 1910, to Aug. 11th, 1910, that I last saw her alive on Aug 11th, 1910, and that death occurred, on the date stated above, at _____ m.AGE 1 yrs. 7 mos. 19 ds. IF LESS than 1 day, _____ hrs. or _____ min.?The CAUSE OF DEATH* was as follows:
Gastro-EnteritisOCCUPATION (a) Trade, profession, or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) NoneBIRTHPLACE (City or town, State or foreign country) St. Louis117R
(Duration) _____ yrs. _____ mos. 18 ds.NAME OF FATHER L. G. SchubertContributory _____
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri(Signed) James A. Dickson M. D.
8/12, 1910 (Address) 1620 Diddle StMAIDEN NAME OF MOTHER O'Shea

*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 (City or town, State or foreign country) St. Louis

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? _____

(Informant) L. G. Schubert

Former or usual residence _____

(ADDRESS) 38199 Hudson PlPLACE OF BURIAL OR REMOVAL Cemetery DATE OF BURIAL AprilAUG 12 1910 Filed _____ 1910 H. W. Wheeler Bond REGISTRARUNDERTAKER Masterman L. Ubo ADDRESS 815 1/2 St

Lates Standard Certificate if Death

ensus and American Public Health Association]

ation.—Precise statement of oc-
tant, so that the relative health-
suits can be known. The ques-
nd every person, irrespective of
ations a single word or term on
fficient, e. g., *Farmer* or *Planter*,
Architect, *Locomotive engineer*,
ary fireman, etc. But in many
ustrial employments, it is neces-
kind of work and also (b) the
or industry, and therefore an
ided for the latter statement; it
hen needed. As examples: (a)
ill; (a) *Salesman*, (b) *Grocery*;
omobile factory. The material
part of the second statement.
er," "Foreman," "Manager,"
more precise specification, as
borer, Laborer—Coal mine, etc.
are engaged in the duties of the
aid *Housekeepers* who receive a
e entered as *Housewife*, *House-*
children, not gainfully employed,
e. Care should be taken to re-
ations of persons engaged in
ge, as *Servant*, *Cook*, *House-*
ation has been changed or given
SEASE CAUSING DEATH, state oc-
if illness. If retired from busi-
indicated thus: *Farmer* (re-
asons who have no occupation

Nomenclature of the
atement of cause of
the head of "Con-
d consequences (e. g.,
ill. The nature
nd of head—homicide;
drowning; Struck by
ossible to determine
SUICIDAL, or HOMIC-
THIS STATE MEANS
ch surgical operation
mia," "PUERPERAL
e childbirth or mis-
s the cause. Always
ness," etc., when a
Old
Heart
"Con-
"Atrophy,"
SEASE CAUSING DEATH, state oc-
if illness. If retired from busi-
indicated thus: *Farmer* (re-
asons who have no occupation
be stated unless im-
tributory (secondary
Chronic

coma, 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* (sec-
ondary), 10 ds. Never report mere symptoms or ter-
minal conditions, such as "Asthenia," "Anaemia"
(merely symptomatic), "Atrophy," "Collapse," "Coma,"
"Convulsions," "Debility" ("Congenital," "Senile," etc.),
"Dropsy," "Exhaustion," "Heart failure," "Haemor-
rhage," "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 septichaemia," "PUERPERAL peritonitis," etc.
State cause for which surgical operation was under-
taken. 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 na-
ture of the injury, as fracture of skull, and conse-
quences (e. g., *sepsis*, *tetanus*) may be stated under the
head of "Contributory." (Recommendations on state-
ment of cause of death approved by Committee on
Nomenclature of the American Medical Association.)

of death.—Name, first, the
(the primary affection with re-
ation), using always the same
ame disease. Examples: *Cere-*
ly definite synonym is "Epidemic
"); *Diphtheria* (avoid use of
ever (never report "Typhoid
pneumonia; *Bronchopneumonia*
ied, is indefinite); *Tuberculosis*
itonaeum, etc., *Carcinoma*, *Sar-*

