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

PLACE OF DEATH

County St. Louis

Township Carondelet

or

Village

or

City (NO. Mt. St Rose Hospital St.: Ward)

Registration District No. 7

Primary Registration District No. 6248

File No. 28500

Registered No. 135

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

FULL NAME Glenn Thomas

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: April 11, 1883 (Month) (Day) (Year)

AGE: 17 yrs. 5 mos. 13 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: At School

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Middleton, Mo

PARENTS

NAME OF FATHER: R E Thomas

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

MAIDEN NAME OF MOTHER: Nannie Ford

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Thomas

(ADDRESS) 439 Wilmington Rd

Filed SEP 25 1910 191 Sub. L. A. Obrock M.D. L. F. O'Brien M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept 25, 1910 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 22, 1910, to Sept 24, 1910, that I last saw him alive on Sept 24, 1910, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

PHTHISIS PULMONALIS

236

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) D R Lamb M. D.

Sept 25 1910 (Address) MOUNT ST. ROSE

*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: Middleton Mo

DATE OF BURIAL: Sept 26 1910

UNDERTAKER: J H Gosken

ADDRESS: 2842 Meramec

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 [illegible]on may form part of the second statement. [illegible] return "Laborer," "Foreman," "Manager," [illegible]" etc., without more precise specification, as [illegible]*orer, Farm laborer, Laborer—Coal mine,* etc. [illegible]at home, who are engaged in the duties of the [illegible]ld only (not paid *Housekeepers* who receive a [illegible] salary), may be entered as *Housewife, House-*[illegible] *At home,* and children, not gainfully employed, [illegible]*chool* or *At home.* Care should be taken to re[illegible]ecifically the occupations of persons engaged in [illegible]c 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 *septichaemia,*" "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.)

STEPHENS, JEFFERSON CITY.