

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.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City St. Louis (NO. Jewish Hosp St. 4 Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 782
1005File No. 32580Registered No. 8275FULL NAME Joseph Goradetsky

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>unk abt 1878</u> (Month) (Day) (Year)		
AGE <u>abt. 32</u> yrs. mos. ds.		IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION

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

BIRTHPLACE

(City or town, State or foreign country) Russia

PARENTS

NAME OF FATHER Perey GoradetskyBIRTHPLACE OF FATHER (City or town, State or foreign country) RussiaMAIDEN NAME OF MOTHER unkBIRTHPLACE OF MOTHER (City or town, State or foreign country) Russia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Dolgin(ADDRESS) 1227 N. 9

OCT 23 1910

Filed

W. H. Board
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10/24/10
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from 10/17/1910, 1910, to 10/23/1910, 1910, that I last saw him alive on 10/23/1910, 1910, and that death occurred, on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH was as follows:

Perforating Ulcer of Large Intestine(Duration) yrs. mos. ds. 14Contributory Peritonitis
(SECONDARY)(Duration) yrs. mos. ds. abt. 3(Signed) S. Burchart M. D.
10/24/1910 (Address) Jewish Hospital

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. 6 ds. In the State ___ yrs. ___ mos. ___ ds.Where was disease contracted if not at place of death? unkFormer or usual residence 1227 N. 9

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Heard St. Emeth Oct. 28, 1910

UNDERTAKER

ADDRESS

H. B. Berger 2127 Barr

United States Standard Certificate of Death

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

need not be

Statement of occupation.—Precise statement of occupation (secondary is very important, so that the relative health or terminal of various pursuits can be known. The question is merely symptomatic to each and every person, irrespective of "Convulsions," "Epilepsy," "Dropsy," "Paralysis," "Inanition," "Weakness," "Compositor, Architect, Locomotive engineer, Miner, 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 cause for which the business or industry, and therefore an appropriate line is provided for the latter statement; it is used only when needed. As examples: (a) *Accidental death*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery store*; (a) *Foreman*, (b) *Automobile factory*. The material on may form part of the second statement. Return "Laborer," "Foreman," "Manager," etc., without more precise specification, as *Miner, Farm laborer, Laborer—Coal mine*, etc. At home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a salary), may be entered as *Housewife, Housewife, At home*, and children, not gainfully employed, as *At home*. Care should be taken to specify the occupations of persons engaged in service for wages, as *Servant, Cook, Housewife*. If the occupation has been changed or given account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business fact may be indicated thus: *Farmer (retired)*. For persons who have no occupation state, 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 term for the same disease. Examples: *Cerebral meningitis* (the only definite synonym is "Epidemic meningitis"); *Diphtheria* (avoid use of "Diphtheritic"); *Typhoid fever* (never report "Typhoid"); *Lobar pneumonia*; *Bronchopneumonia* (unqualified, is indefinite); *Tuberculosis meningitis, 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.)

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