

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 St LouisTownship Central

or

Village _____

or

City _____

Registration District No. 790File No. 35542Primary Registration District No. 6033Registered No. 220(NO St Vincent Inst St.: _____ Ward)

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

FULL NAME Sister Frances Heeren

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH _____ (Month) (Day) (Year)		
AGE <u>67</u> yrs. — mos. — ds. If LESS than 1 day, ___ hrs. or ___ min.?		
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>Sister of Charity</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Massachusetts</u>		
PARENTS	NAME OF FATHER <u>Don't Know</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>n n</u>	
	MAIDEN NAME OF MOTHER <u>n n</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>n n</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Mary Rose(ADDRESS) St Vincent InstFiled 11/201910REGISTRAR G. Glogger

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

November 20, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 2nd, 1910, to Nov. 19th, 1910, that I last saw her alive on Nov. 19th, 1910, and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma
3 in water
95 B
106 D (Duration) ___ yrs. ___ mos. ___ ds.
Contributory Bronchitis
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) H. M. Norman M. D.
Nov. 20th, 1910 (Address) 3154 Delmar Av.

*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 21 yrs. ___ mos. ___ ds. In the State 21 yrs. ___ mos. ___ ds.

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

Former or usual residence St. Vincent's Institution

PLACE OF BURIAL OR REMOVAL

Calvary Cemetery

DATE OF BURIAL

Nov. 21, 1910

UNDERTAKER

Cullen Kelly

ADDRESS

2735-Cass

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 especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the name of the business or industry, and therefore an additional line is provided for the latter statement; it shall be used only when needed. As examples: (a) *Farmer*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery store*; (a) *Foreman*, (b) *Automobile factory*. The material on this line may form part of the second statement.

Persons who are engaged in the duties of the household only (not paid *Housekeepers* who receive a wage or salary), may be entered as *Housewife*, *Housekeeper*, *At home*, and children, not gainfully employed, as *At home*. Care should be taken to record 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, the fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no 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 at beginning of illness, write *None*.

Statement of cause of death.—Name, first, the primary affection with 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 fever"); *Lobar pneumonia*; *Bronchopneumonia*; *Tuberculosis*, 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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HUGH STEPHENS, JEFFERSON CITY.

