

PLACE OF DEATH

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

County _____

Township _____

or _____

Village _____

or _____

City St Louis (NO. Ward)Registration District No. 891File No. 22586Primary Registration District No. 1003Registered No. 5420FULL NAME William Birkheimer

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED SingleDATE OF BIRTH Dec 14 - 1910
(Month) (Day) (Year)AGE X 5 23 If LESS than 1 day, _____ hrs. or _____ min.?
_____ yrs. _____ mo. _____ ds.OCCUPATION (a) Trade, profession, or particular kind of work Stone
(b) General nature of industry, business, or establishment in which employed (or employer) StoneBIRTHPLACE (City or town, State or foreign country) St LouisPARENTS NAME OF FATHER William Stimmey
BIRTHPLACE OF FATHER (City or town, State or foreign country) St Louis
MAIDEN NAME OF MOTHER Anna Birkheimer
BIRTHPLACE OF MOTHER (City or town, State or foreign country) St Louis

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Birkheimer(ADDRESS) 1309 StowardFiled JUN -8 1911 1911Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 7, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from June 1st, 1911, to June 7, 1911,
that I last saw him alive on June 6th, 1911,
and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

11957
1066 Gastro Enteritis, Duetetic
104
(Duration) _____ yrs. _____ mos. 7 ds.Contributory Bronchitis - 7
(SECONDARY) (Duration) _____ yrs. _____ mos. 2 ds.(Signed) Geo. A. Melliss M. D.
June 7, 1911. (Address) 2839 Cass ave

*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. 1 mos. 9 ds. In the State yrs. _____ mos. _____ ds.

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

Former or usual residence Female HospitalPLACE OF BURIAL OR REMOVAL St Ann Cem DATE OF BURIAL June 8, 1911UNDERTAKER Messers L & M Co ADDRESS 1100 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*, *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) *Cotton 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*, *Sar-*

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* (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.)

