

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.

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

PLACE OF DEATH

County _____
Township _____
or
Village _____
or
City St. Louis Mo. (NO. 28007 Taylor St. _____ Ward)

Registration District No. 791 File No. 29698
Primary Registration District No. 1008 Registered No. 7424

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

FULL NAME William H. ...

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH April 15, 1910
(Month) (Day) (Year)

AGE 1 yrs. 3 mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

DATE OF DEATH Aug 9, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 2, 1911, to Aug 9, 1911, that I last saw him alive on Aug 9, 1911, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Angio-sarcoma
46E
55F

BIRTHPLACE (City or town, State or foreign country) Ill

PARENTS

NAME OF FATHER James Tarnelle
BIRTHPLACE OF FATHER (City or town, State or foreign country) Italy
MAIDEN NAME OF MOTHER Maria Tarnella
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Italy

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory none
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. H. ... M. D.
1911 (Address) 2800 N. Taylor

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Tarnelle
(ADDRESS) Hillsborough Ill
AUG -3 1911 Max C. Starkloff
Filed _____ 1911 REGISTERER

*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 Hillsborough Ill

PLACE OF BURIAL OR REMOVAL Calvary Cem. DATE OF BURIAL Aug 10, 1911
UNDERTAKER W. H. ... ADDRESS Ev. N. Co 1024 Pundt...

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 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," "Anacmia" (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.)



PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 7424(NO. 2800 N. Taylor)

St.:

Ward)

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

FULL NAME Stephen Terravella

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) 1DATE OF BIRTH 4 - 15 - 1910

(Month)

(Day)

(Year)

AGE 1 2 24yrs. 2 mos. 24 ds.

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

OCCUPATION (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) Italy

PARENTS

NAME OF FATHER James TerravellaBIRTHPLACE OF FATHER (City or town, State or foreign country) ItalyMAIDEN NAME OF MOTHER Maria CarusoBIRTHPLACE OF MOTHER (City or town, State or foreign country) Italy

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Terravella(ADDRESS) Hillsborough, Ill.Filed Oct 12 1911G. E. Snodgrass

REGISTRAR

Original file, date. Aug, 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8 - 9 - 1911

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from 8 - 9 - 1911, to 8 - 9 - 1911,that I last saw him alive on 8 - 9 - 1911, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Myo-sarcoma of Liver

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Robinson M. D.(Address) 2800 N. Taylor

*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. 7 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence Hillsborough, Ill.PLACE OF BURIAL OR REMOVAL Calvary Cem.DATE OF BURIAL 8 - 10 - 1911UNDERTAKER William L. + N. Co.ADDRESS 1024 Lindbergh

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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