

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City St. LouisRegistration District No. 791File No. 29977Primary Registration District No. 7008Registered No. 7722St. 73 Ward

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

FULL NAME Curtis Reeder

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If write the word)MaleColoredSingle

DATE OF BIRTH

March
(Month)29, 1879
(Day) (Year)

AGE

33 yrs. 4 mos. 16 ds.If LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Hostler(b) General nature of industry, business, or establishment in which employed (or employer) 4-12

BIRTHPLACE

(City or town, State or foreign country) Alabama

PARENTS

NAME OF FATHER John ReederBIRTHPLACE OF FATHER (City or town, State or foreign country) AlabamaMAIDEN NAME OF MOTHER Angeline ThompsonBIRTHPLACE OF MOTHER (City or town, State or foreign country) Georgia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Hill(ADDRESS) City Hospital

Filed

AUG 13 1911May C. Stackloff

REGISTRAR

DATE OF DEATH

August
(Month)14, 1911
(Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

August 2, 1911, to August 14, 1911,
that I last saw him alive on August 14, 1911,
and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Les

Contributory

(SECONDARY)

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

(Signed) J. H. Swearing M. D.August 15, 1911 (Address) City Hospital

State the Disease Causing Death, or, in death 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. 12 ds. In the State 7 yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former of usual residence 4059 Highway Ave.PLACE OF BURIAL OR REMOVAL City HospitalDATE OF BURIAL Aug 18, 1911UNDERTAKER M. H. AlexanderADDRESS 2833 Olive

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.

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*, *peritonaeum*, 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.)



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 _____ (NO. _____) (St. _____ Ward)

Registration District No. 491 File No. _____

Former Registration District No. 1003 Registered No. 7722

St. _____ Ward _____

FULL NAME Curtis Reeder

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (If wife the word)

DATE OF BIRTH 3 29 1894
(Month) (Day) (Year)

AGE 33 yrs 4 mos 16 ds. IF LESS than 1 day, ___ hrs or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) St. Louis, Mo.

PARENTS
NAME OF FATHER John Reeder
BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis, Mo.
MAIDEN NAME OF MOTHER Emma Thompson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) St. Louis, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. Hill
(ADDRESS) My Hospital

Filed Oct. 7 1911 A. G. Snodgrass REGISTRAR

Original file, date _____, 19____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 14, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911, that I last saw him alive on _____, 1911, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH was as follows:
Chorea of the heart
d.t.s.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. A. Simpson M.D.
7-15, 1911 (Address) My 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. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
Former or usual residence 405-9 Trinity Ave.

PLACE OF BURIAL OR REMOVAL Anatomical Board DATE OF BURIAL 8-18, 1911
UNDERTAKER M. H. Alexander ADDRESS 2835 Olive

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

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