

## PLACE OF DEATH

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

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City St. Louis Mo. (NO. Childrens Home So. St. 71 Ward)Registration District No. 791Primary Registration District No. 1003File No. 20146Registered No. 7901

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

FULL NAME Charles Edwin Hentz

## PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED single  
(Write the word)DATE OF BIRTH June 24, 1911  
(Month) (Day) (Year)AGE 2 yrs. 2 mos. 2 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) \_\_\_\_\_

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

PARENTS	NAME OF FATHER <u>Charles Grant</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u>
	MAIDEN NAME OF MOTHER <u>Johanna Hentz</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Edwardsville, Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Childrens Home Society  
O. Byrne, Nurse  
(ADDRESS) 4427 Margaret Ave.Filed AUG 25 1911 Max C. Starkloff REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 24, 1911  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug 19, 1911, to Aug 24, 1911, that I last saw him alive on Aug 23, 1911, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH\* was as follows:

Malnutrition  
(Duration) \_\_\_ yrs. 2 mos. 24 ds.Contributory (SECONDARY) Malnutrition  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.(Signed) L. C. M. Egan M. D.  
Aug 24, 1911 (Address) 1221 N. Grand

\*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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Cotters Field DATE OF BURIAL 8-26 1911UNDERTAKER John J. Fleming ADDRESS 1426 Sandusky

# 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.)



PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

(County) \_\_\_\_\_ Registration District No. 991 File No. \_\_\_\_\_  
Township \_\_\_\_\_ or \_\_\_\_\_ Primary Registration District No. 1003 Registered No. 7901  
Village \_\_\_\_\_ or \_\_\_\_\_ (NO. Children Home Socy, St. 2 Ward) [If death occurred in a  
City St. Louis hospital or institution, give its NAME instead of street and number]

FULL NAME Charles Edwin Dentz

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED 1  
(Write the word)  
DATE OF BIRTH June 24, 1911  
(Month) (Day) (Year)  
AGE 2 yrs. 2 mos. 2 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min. ?

DATE OF DEATH 8-24, 1911  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1911, to 8-24, 1911, that I last saw him alive on 8-24, 1911, and that death occurred, on the date stated above, at 9h m. The CAUSE OF DEATH was as follows:

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

~~Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.~~

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

PARENTS NAME OF FATHER Charles Dentz BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis, Mo.  
MAIDEN NAME OF MOTHER Johnna Dentz BIRTHPLACE OF MOTHER (City or town, State or foreign country) St. Louis, Mo.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) L. W. M. Dentz M. D. 8-24, 1911 (Address) 1221 N. Grand

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Children Home Socy (ADDRESS) 2 Byrne Station

\*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 \_\_\_\_\_

Filed Oct 7, 1911 J. G. Spodgrass REGISTRAR

PLACE OF BURIAL OR REMOVAL Peters Field DATE OF BURIAL 8-26, 1911  
UNDERTAKER J. J. Fanning ADDRESS 1736 Carroll

Original file, date \_\_\_\_\_, 19\_\_\_\_. All information called for must be written on this Supplementary Certificate.

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