

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. 33213Primary Registration District No. 1003Registered No. 8703(NO. City Hospital St. 15 Ward)

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

FULL NAME Jack Barnett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED married
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

(Month)

(Day)

(Year)

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

yrs.

mos.

ds.

IF LESS than
1 day, ____ hrs.
or ____ min.?I HEREBY CERTIFY, that I attended deceased from Sept 20, 1911, to Sept 25, 1911, that I last saw him alive on Sept 21, 1911, and that death occurred, on the date stated above, at 2:30 pm.

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)

Carpenter5-01131 Nephritis9 yrs

BIRTHPLACE

(City or town, State or foreign country)

Illinois

(Duration)

yrs.

mos.

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

NAME OF FATHER

Benjamin Barnett

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Illinois

MAIDEN NAME OF MOTHER

Mary Anglen

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Illinois

(Signed)

W. H. Sewing M. D.(Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

City Hospital

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. 4 ds. In the State ____ yrs. 10 mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence 2221 Hickory

PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

Concordia Sept 26 1911

UNDERTAKER

ADDRESS 2652E. J. Labrus Chauncey

Filed

SEP 26 1911

Max C. Starkloff

REGISTRAR

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*, *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 septichaemia," "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 RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

County _____
Township _____ or Village _____ or City St. Louis (NO. City Corps)
Registration District No. 791 File No. _____
Primary Registration District No. 1003 Registered No. 8703
St.: _____ Ward _____

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

FULL NAME Jack Bennett

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
DATE OF BIRTH <u>7-10</u> , 18 <u>86</u> (Month) (Day) (Year)		
AGE <u>43</u> yrs. <u>2</u> mos. <u>14</u> ds. if LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Carpenter</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

BIRTHPLACE (City or town, State or foreign country) <u>Ill.</u>	
PARENTS	NAME OF FATHER <u>Wm. Bennett</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>
	MAIDEN NAME OF MOTHER <u>Mrs. Anglin</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ill.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. Bennett
(ADDRESS) City Corps

Filed Nov 4 1917 at St. Louis Mo. by Wm. Bennett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 1917
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1917, to _____, 1917, that I last saw him alive on _____, 1917, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

x Chronic Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Mitral Insufficiency
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Wm. Bennett M. D.
9-25, 1917 (Address) City Corps

*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. 4 ds. In the State _____ yrs. 0 mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence 2771 Hickory

PLACE OF BURIAL OR REMOVAL Cremation DATE OF BURIAL 9-26, 1917

UNDERTAKER E. J. Schum ADDRESS Chautau

Original file, date 9-26, 1917

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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