

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City St. Louis (NO. 662)Registration District No. 79 IFile No. 39876Primary Registration District No. 1003Registered No. 10339City City Hospital St. 2 Ward

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

FULL NAME Wm. Baker Quiet

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(If write the word)DATE OF BIRTH Jan 14 1889
(Month) (Day) (Year)AGE 72 yrs. 11 mos. 4 ds. If LESS than
1 day, ___ hrs.
or ___ min.?OCCUPATION
(a) Trade, profession, or particular kind of work sewing machine business
(b) General nature of industry, business, or establishment in which employed (or employer)BIRTHPLACE
(City or town, State or foreign country) IllinoisNAME OF FATHER George QuietBIRTHPLACE OF FATHER
(City or town, State or foreign country) IllinoisMAIDEN NAME OF MOTHER Not knownBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Not knownTHE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Wm. Starkloff(Informant) E. Koban(ADDRESS) City HospitalFiled NOV 24 1911 Wm. Starkloff

REGISTRAR

DATE OF DEATH Nov 18 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Nov 8, 1911, to Nov 18, 1911, that I last saw him live on Nov 18, 1911, and that death occurred, on the date stated above, at 5:00 p.m.The CAUSE OF DEATH* was as follows:
Acute dilatation Heart95 B

(Duration) yrs. mos. ds.

Contributory Uncompensated Heart
(SECONDARY) (Duration) yrs. mos. ds.(Signed) A. H. Swain M. D.
Nov 19 1911 (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.

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

At place of death yrs. mos. ds. In the State 22 yrs. mos. ds.Where was disease contracted if not at place of death?
Former or usual residence 1572 Narine AvePLACE OF BURIAL OR REMOVAL COTTERS FIELDDATE OF BURIAL Nov 25 1911UNDERTAKER John J. FanningADDRESS 1426 Carroll

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, 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," "Hæmorrhage," "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

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

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

County _____

Township _____

or _____

Village _____

or _____

City St Louis (NO _____ St.: _____ Ward)Registration District No. 791 File No. _____Primary Registration District No. 1003 Registered No. 10339

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

FULL NAME Wm T Baker Jones

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) singleDATE OF BIRTH 1-14-1839
(Month) (Day) (Year)AGE 77 yrs. 11 mos. 4 ds. If LESS than 1 day, ___ hrs or ___ min.OCCUPATION
(a) Trade, profession, or particular kind of work Not obtainable
(b) General nature of industry, business, or establishment in which employed (or employer) Living MedicineBIRTHPLACE
(City or town, State or foreign country) IllinoisNAME OF FATHER Jos BakerBIRTHPLACE OF FATHER
(City or town, State or foreign country) IllMAIDEN NAME OF MOTHER CarrollBIRTHPLACE OF MOTHER
(City or town, State or foreign country) "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. H. ...(ADDRESS) City MoFiled 1-4 X 1912 9. G. Snodgrass REGISTRAROriginal file date NOV 5 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-18, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from 11-18, 1911, to 11-18, 1911, that I last saw him alive on ", 1911, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH was as follows:

Acute Dilated Heart
Coronary artery
transmural heart
(Duration) ___ yrs. ___ mos. ___ ds.(Signed) Art. Sweeney M. D.
11-19, 1911 (Address) City Mo

*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 Patterson Field DATE OF BURIAL 11/25, 1911UNDERTAKER Jos J. Harrington ADDRESS 1426 Carroll

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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