

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

Registration District No. 791

File No. 40000

Primary Registration District No. 1003

Registered No. 10470

NO. 1110 N. 24th

St. 18 Ward

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

FULL NAME John Kennedy

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH November 27th, 1911
(Month) (Day) (Year)

DATE OF BIRTH Feb 6, 1858
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 27th, 1911, to Nov 27, 1911, that I last saw him live on Nov. 27th, 1911,

AGE 53 yrs. 9 mos. 21 ds. If LESS than 1 day, _____ hrs. or _____ min.?

and that death occurred, on the date stated above, at 7:30 m.

OCCUPATION (a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Street Exp. Co.

The CAUSE OF DEATH* was as follows:
Cirrhosis of the liver
12410

BIRTHPLACE (City or town, State or foreign country) New York

I don't know. Under my care
(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER Michael Kennedy

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ireland

(Signed) Orlando G. Gibson M. D.
Nov 28, 1911 (Address) St Louis Mo

MAIDEN NAME OF MOTHER Margaret Lower

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ireland

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Informant) Mrs A Waye
(ADDRESS) 1110 N 24th St

Where was disease contracted if not at place of death?

Former or usual residence _____

Filed NOV 28 1911 Max Cottarkloff
REGISTRAR

PLACE OF BURIAL OR REMOVAL ST. FERDINAND'S CEMETARY FLORISSANT MO.
DATE OF BURIAL Nov. 29, 1911
UNDERTAKER Wormely Bros ADDRESS 3756 Olive St.

Certificate

Public Health

Statement of occupational health-

The respective of for term on or Planter, or engineer, but in many it is neces-

Also (b) the of the business or industry, and therefore an onal line is provided for the latter statement; it l be used only when needed. As examples: (a) er, (b) Cotton mill; (a) Salesman, (b) Grocery; foreman, (b) Automobile factory. The material d on may form part of the second statement. return "Laborer," "Foreman," "Manager," r," etc., without more precise specification, as laborer, Farm laborer, Laborer—Coal mine, etc. n at home, who are engaged in the duties of the old only (not paid Housekeepers who receive a salary), may be entered as Housewife, House- or At home, and children, not gainfully employed, school or At home. Care should be taken to re- cifically the occupations of persons engaged in ic service for wages, as Servant, Cook, House- tc. If the occupation has been changed or given account of the DISEASE CAUSING DEATH, state oc- .t beginning of illness. If retired from busi- a. fact may be indicated thus: Farmer (re- u 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. Nature of the injury, as fracture of skull, and circumstances (e. g., sepsis, tetanus) may be stated in head of "Contributory." (Recommendations: Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MIS

PLEASE PRINT CLEARLY
GIVE A FEE FOR SERVICE
UNTIL THEY ARE COLLECTED
PRESCRIBED BY LAW.

DEATH

