

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. 42896

Primary Registration District No. 1003

Registered No. 10787

(No. 1711 Morgan St St. 5 Ward)

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

FULL NAME Robert McCombe

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>Cold</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> <small>(Write the word)</small>
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DATE OF BIRTH Dec. 26, 1877
(Month) (Day) (Year)

AGE 34 yrs 11 mos. 10 ds.
If LESS than 1 day, ____ hrs or ____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) mo. 4-09

PARENTS	NAME OF FATHER <u>Jno. McCombe</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>mo.</u>
	MAIDEN NAME OF MOTHER <u>Mary Abernathy</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella McShee
(ADDRESS) 1019 N. 12th

Filed DEC -8 1911 Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 6, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 18, 1911, to Dec 6, 1911, that I last saw him alive on Dec 6, 1911, and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Consumption
23 1/2
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(SECONDARY) 9 (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Vincent J. Mueller M. D.
Dec 8, 1911 (Address) 2600 Franklin

*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 <u>Greenwood</u>	DATE OF BURIAL <u>Dec. 9 1911</u>
UNDERTAKER <u>Harrison McKoin</u>	ADDRESS <u>2906 Lantier</u>

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," "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

REGISTRARS SHALL NOT RE-
CEIVE 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. 1711 Morgan St. St.; _____ Ward)

Registration District No. 791 File No. _____
Primary Registration District No. 1003 Registered No. 10787

FULL NAME Robert McCoombs

[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 colored SINGLE MARRIED married
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH Dec 26, 1877
(Month) (Day) (Year)

AGE 34 yrs. 11 mos. 10 ds. IF LESS than
1 day, _____ hrs. or _____ min.

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

BIRTHPLACE
(City or town, State or foreign country) Mo

NAME OF FATHER Geo McCoombs

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

MAIDEN NAME OF MOTHER Sarah Abernathy

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Mcghee
(ADDRESS) 1017 1/2 12th

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 6, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 18, 1911, to Dec 6, 1911,
that I last saw him alive on Dec 6, 1911,
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) _____ yrs. 4 mos. _____ ds.

Contributory _____
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. Vincent J. MacCallister
2-8, 1912 (Address) 2600 Franklin

*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 _____ DATE OF BURIAL _____ 1911

Filed 229 1912 A. L. Snodgrass REGISTRAR
Dec 1

Original file, date DEC 1 1911 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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42896
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