

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 (NO. 1802 N. Leffingwell Ward)

Registration District No. 791 File No. 43094
 Primary Registration District No. 1003 Registered No. 10996

FULL NAME Mary Smith

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>married</u>
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DATE OF BIRTH _____
 (Month) _____ (Day) 18 (Year) 1867

AGE 44 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) 9-0

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

PARENTS	NAME OF FATHER <u>Matthew Carroll</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ireland</u>
	MAIDEN NAME OF MOTHER <u>Sarah Carroll</u> <u>nee Carroll</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ireland</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) H. J. Smith

(ADDRESS) 1802 N. Leffingwell

Filed DEC 15 1911 at Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 14, 1911
 (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1911 to Dec 14, 1911, that I last saw her alive on Dec 14, 1911, and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Salpingitis
1398
 (Duration) unknown about 8 years ds.

Contributory Heart Failure
 (SECONDARY) (Duration) _____ yrs. _____ mos. 2 hrs. ds.

(Signed) J. C. Calverton M. D.
Dec 14, 1911 (Address) 1310 N. Grand Ave

*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>Calverton</u>	DATE OF BURIAL <u>12-16</u> , 19 <u>11</u>
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UNDERTAKER <u>William Kelly</u>	ADDRESS <u>2735 Cass Ave</u>
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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*, *peritonaeum*, 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.)

HUGH STEPHENS, JEFFERSON CITY.



PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____
Township _____ or Village _____
City St Louis (NO. 1802 N. Leffingwell ave Ward) Registration District No. 791 File No. _____Primary Registration District No. 1003 Registered No. 10996
City St Louis (NO. 1802 N. Leffingwell ave Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

Mary Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) marriedDATE OF BIRTH 27 35 1867 (Month) 27 (Day) 35 (Year) 1867AGE 44 yrs. 27 mos. 35 ds. IF LESS than 1 day, hrs. or min.

OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

St Louis

NAME OF FATHER

Matthew Carroll

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

Ireland

MAIDEN NAME OF MOTHER

Sarah Carroll

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

Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. J. Smith(ADDRESS) 1802 N. LeffingwellFiled 2-15 1929 by A. J. Ansdgrat REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 14, 1911 (Month) (Day) (Year)HEREBY CERTIFY, that I attended deceased from Dec 10, 1911, to Dec 14, 1911, that I last saw her alive on " ", 1911, and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH was as follows:

Chronic SalpingitisContributory Heart Failure (SECONDARY) (Duration) unknown about 8 yrs yrs. mos. 2 hrs.(Signed) J. A. Calnan M. D. Dec. 14, 1911 (Address) 1310 N. Grand Ave.

*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 Calvary DATE OF BURIAL 12-16, 1911UNDERTAKER William Kelley ADDRESS 2535 Cass Ave.

Original file, date _____, 19____

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]

43094

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