

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

PLACE OF DEATH

County _____
Township _____
or
Village _____
or
City St. Louis (NO. _____)

Registration District No. 791
Primary Registration District No. 1003
File No. 43102
Registered No. 11005

Ward 4 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Louise Wilson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female **COLOR OR RACE** Colored **SINGLE MARRIED WIDOWED OR DIVORCED** Widowed
(Write the word)

DATE OF BIRTH Could not be obtained 1867
(Month) (Day) (Year)

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

OCCUPATION
(a) Trade, profession, or particular kind of work Laudress
(b) General nature of industry, business, or establishment in which employed (or employer) g. 22

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

PARENTS
NAME OF FATHER Could not be obtained
BIRTHPLACE OF FATHER Could not be obtained
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Could not be obtained
BIRTHPLACE OF MOTHER Could not be obtained
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ch. Roman

(ADDRESS) City Hospital

Filed DEC 15 1911 Max C. Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 11, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 9, 1911, to Dec 11, 1911, that I last saw her alive on Dec 11, 1911, and that death occurred, on the date stated above, at 10¹⁵ a.m.

The CAUSE OF DEATH* was as follows:
Purulent Meningitis
13.1
1911
(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) A. J. Swiney M. D.
Dec 12, 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. 2 ds. In the 14 State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
Former or usual residence 1706 Biddle (over)

PLACE OF BURIAL OR REMOVAL POTTERS FIELD **DATE OF BURIAL** 12-16, 1911

UNDERTAKER John J. Manning **ADDRESS** 1425 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," "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.)



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 Hospital St. 7 Ward _____)

Registration District No. 791 File No. _____

Primary Registration District No. 1003 Registered No. 11005

FULL NAME Laurie Wilson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX ♀ COLOR OR RACE colored SINGLE MARRIED Wed. WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH mm 1867
(Month) (Day) (Year)

AGE 44 yrs. mos. ds. If LESS than 1 day, hrs. or min. 2

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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 11 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 9, 1911, to Dec 11, 1911, that I last saw her alive on Dec 11, 1911, and that death occurred, on the date stated above, at 10 100 m.

The CAUSE OF DEATH* was as follows:
Purulent Meningitis (non-epidemic)

(Duration) yrs. mos. ds.

PARENTS

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

Contributory Ch. Meningitis & Tuberculosis
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. P. Brooks M. D.
2-15, 1912 (Address) City Hospital

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Rowan
(ADDRESS) City Hospital

Filed 2-15 1912 A. H. Snodgrass REGISTRAR

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 2 yrs. 14 mos. 14 ds. In the State 14 yrs. 14 mos. 14 ds.

Where was disease contracted if not at place of death?
Former or usual residence 1706 Biddle (rear)

PLACE OF BURIAL OR REMOVAL Patterson's field DATE OF BURIAL 12-16 1911

UNDERTAKER John J. Fanning ADDRESS 1426 Carroll

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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43102
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