

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.

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....

Registration District No. 791

791

File No.

7520

Primary Registration District No. 1003

1003

Registered No.

1883

City St. Louis (NO. Alexian Bros. Hosp St. 10 Ward)FULL NAME John Landers

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
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DATE OF BIRTH

May 20, 1877
(Month) (Day) (Year)

AGE

34 yrs. 10 mos. 7 ds.
If LESS than 1 day, hrs. or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Seamster 104(b) General nature of industry, business, or establishment in which employed (or employer) Government 74

BIRTHPLACE

(City or town, State or foreign country) MissouriNAME OF FATHER Wm. LanderBIRTHPLACE OF FATHER (City or town, State or foreign country) St. LouisMAIDEN NAME OF MOTHER Louisa KoengerBIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Meike Lander(ADDRESS) St. Louis CoFiled FEB 25 1912Mayb Starkloff

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Feb 24, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 19~~th~~, 1912, to Feb 24, 1912, that I last saw him alive on Feb 23, 1912,

and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

B Cerebro-spinal meningitis,
Schick toxin pyogenic
(Non-Epidemic)

(Duration) — yrs. — mos. 4 ds.Contributory Ethmoiditis

(SECONDARY)

(Duration) — yrs. — mos. — ds.

(Signed) W. M. C. Bryan M. D.Feb 24, 1912. (Address) Metropolitan Bldg

*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. 4 ds. In the State — yrs. — mos. — ds.Where was disease contracted if not at place of death? RFormer or usual residence King's Road St. Louis Co

PLACE OF BURIAL OR REMOVAL

Assumption Matrone

DATE OF BURIAL

Feb 27, 1912

UNDERTAKER

Chopmist-Hill 7814 Belmont

ADDRESS

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 septichaemia," "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.)



WRITE PLAINLY. WITH LEADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. PAGE 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 _____

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

Township _____

Registration District No. 791

File No. _____

Village _____

Primary Registration District No. 1003

Registered No. 1883

City St Louis

NO. Alexan Bro Hosp St. Ward

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

FULL NAME

John Landers

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) wd

DATE OF BIRTH May 20 1877 (Month) (Day) (Year)

AGE 34 yrs. 10 mos. 2 ds. IF LESS than 1 day, hrs. or min?

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

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

NAME OF FATHER Mike Landers

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

MAIDEN NAME OF MOTHER Luisa Kornger

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mike Landers

(ADDRESS) St Louis Mo.

Filed 4-14 1912 U.S. Snodgrass Dep REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 24 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 14 1912, to Feb 24 1912, that last saw him alive on Feb 23 1912, and that death occurred, on the date stated above, at 9:15-a.m.

The CAUSE OF DEATH* was as follows: Subarachnoid meningitis Streptococcus Echinoiditis

Contributory Echinoiditis (Duration) yrs. mos. ds.

(Signed) W. M. C. Bryan M. D. April 13, 1912 (Address) Metropolitan Bldg

*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 Resurrection Methn Co DATE OF BURIAL 2/21 1912

UNDERTAKER Hoffmister W. Co ADDRESS 7814 S. Blvd.

Revised United States Standard Certificate of Death

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

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