

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 St. Louis
Township Bohannan
or
Village Kirkwood
or
City Mo. (NO. 242 W. W. Robbins Ave. St.: 3rd Ward)

Registration District No. 785 File No. 14801
Primary Registration District No. 3037 Registered No. 65

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

FULL NAME Mrs. Susan Mack Ryan

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Caucasian SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH October 12th, 1876
(Month) (Day) (Year)

AGE 35 yrs. 5 mos. 29 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Ballwin, Mo. U.S.A.

PARENTS
NAME OF FATHER William E. Hayes
BIRTHPLACE OF FATHER (City or town, State or foreign country) St. Louis, Mo.
MAIDEN NAME OF MOTHER Martin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ballwin, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward W. Hayes
(ADDRESS) Kirkwood, Mo.

Filed Apr 14, 1912 C. A. Dummerack
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 11th, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 26, 1911, to April 11th, 1912, that I last saw her alive on April 11th, 1912, and that death occurred, on the date stated above, at 6:45 am.

The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonalis
V3H

Contributor (SECONDARY) Tuberculosis of lungs
(Duration) 3 yrs. ___ mos. ___ ds.

(Signed) Robt. C. Fray M. D.
April 13, 1912 (Address) Kirkwood, Mo.

*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 St. Peter's DATE OF BURIAL April 16, 1912

UNDERTAKER A. H. Hoff ADDRESS Kirkwood, Mo.

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, Composer, 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," "Convulsion," "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

County St LouisREGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

Township _____

or Kirkwood

Village _____

or _____

City _____

Registration District No. 785File No. 14801Primary Registration District No. 3037Registered No. 65(NO. 242 W. Woodbine St.: 2nd Ward)[If death occurred in a
hospital or institution,
give its NAME instead
of street and number]FULL NAME Mrs Susan Mack Ryan

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED M.
(Write the word)DATE OF BIRTH Oct. 12, 1876
(Month) (Day) (Year)AGE 35 yrs. 5 mos. 29 ds. IF LESS than
1 day, ___ hrs. or ___ min.OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____BIRTHPLACE
(City or town, State or foreign country) Ballwin Mo.NAME OF FATHER William HayesBIRTHPLACE OF FATHER
(City or town, State or foreign country) St Louis Mo.MAIDEN NAME OF MOTHER Jessie MartinBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Ballwin Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward W Hayes(ADDRESS) KirkwoodFiled 6-6- 192 Pl Dummwack

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 11, 192
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Apr 6, 192, to Apr. 11, 192,
that I last saw her alive on Apr. 11, 192,
and that death occurred, on the date stated above, at 6:45 a.m.The CAUSE OF DEATH* was as follows:
phthisis pulmonalis(Duration) 3 yrs. ___ mos. ___ ds.Contributory, Tuberculosis of larynx
(SECONDARY)(Duration) ___ yrs. 6 mos. ___ ds.(Signed) Rot E. Forayth M. D.Apr 13, 192 (Address) Kirkwood Mo.

*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 St Peters CentDATE OF BURIAL Apr 12, 192UNDERTAKER L N BoppADDRESS Kirkwood Mo.

Revised United States Standard Certificate of Death

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

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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.)