

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH \_\_\_\_\_

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City St. Louis Mo.

Registration District No. 791

File No. 15401

Primary Registration District No. 1003

Registered No. 3650

(NO. 4019 @ Shenandoah St. 13 Ward)

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

FULL NAME Ruth Clotfelter

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (If write the word)
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DATE OF BIRTH 9 (Month) 18 (Day) 1899 (Year)

AGE 12 yrs. 7 mos.  ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Hillsboro Ill

PARENTS	NAME OF FATHER <u>Frank Clotfelter</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hillsboro Ill</u>
	MAIDEN NAME OF MOTHER <u>Maud My Church</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Irving Ill</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Mrs. M. Clotfelter  
(ADDRESS) 4019 @ Shenandoah

Filed APR 17 1912 Max Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Apr 17<sup>th</sup> (Month)  (Day) 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 12, 1912, to Apr 16, 1912, that I last saw her alive on Apr 16, 1912, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH\* was as follows:  
Chronic Spinal Meningitis  
non tubercular  
9 (Duration) 6 yrs.  mos.  ds.

Contributory Over exertion (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) Adrian Blichote M.D.  
4/17, 1912 (Address) 879 Langdon & Pugh

\*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>Hillsboro Ill</u>	DATE OF BURIAL <u>4/18</u> , 191 <u>2</u>
UNDERTAKER <u>Army Emr 3434 Shenandoah</u>	ADDRESS <u></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*, *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," "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 Non-enclature of the American Medical Association.)



RECORDING INFORMATION - THIS IS A PERMANENT RECORD

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

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

PLACE OF DEATH \_\_\_\_\_  
 County St. Louis  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City St. Louis  
 Registration District No. 791 File No. \_\_\_\_\_  
 Primary Registration District No. 1003 Registered No. 3650  
 (NO. 4019A. Shenandoah. St. 13" Ward)  
 FULL NAME Ruth Clotfelder  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>F.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> <small>(Write the word)</small>
DATE OF BIRTH <u>9 18 1899</u> <small>(Month) (Day) (Year)</small>		
AGE <u>12</u> yrs. <u>7</u> mos. <u></u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>School girl</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Hillsboro Ill.</u>		
PARENTS	NAME OF FATHER <u>Frank Clotfelder</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Hillsboro Ill.</u>	
	MAIDEN NAME OF MOTHER <u>Maggie Upchurch</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Irving Ill.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs M. Clotfelder</u> (ADDRESS) <u>4019 A. Shenandoah</u>		
Filed <u>June 7 1912</u> <u>A. E. Suedgen</u> REGISTRAR <u>Amie</u>		

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Feb 27 (Month) Apr. 17 (Day), 1912 (Year)  
 I HEREBY CERTIFY, that I attended deceased from Feb 27, 1912, to Apr. 16, 1912, that I last saw h. w. alive on Apr. 11, 1912, and that death occurred, on the date stated above, at 4:30 a.m.  
 The CAUSE OF DEATH\* was as follows:  
Chronic Spinal Meningitis  
It had been chronic for 6 years and had previously caused blindness - evidently of tubercular origin for 2 years.  
 Contributory Overexertion.  
 (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 2 ds.  
 (Signed) Adrian Nichols D.D. M.D.  
417, 1912 (Address) 819 Cangan & Taylor  
 \*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 Hillsboro Ill. DATE OF BURIAL 4/18, 1912  
 UNDERTAKER Henry Hener ADDRESS 3434 Shenandoah

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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**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*, *Sarcoma*, 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 "Asthma," "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.)

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