

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. **791**

File No. **2136**

Primary Registration District No. **1003**

Registered No. **5218**

Ward **3**

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

FULL NAME

St. Louis
2109 N. Eleventh
Unnamed Lubin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *female* COLOR OR RACE *white* SINGLE MARRIED OR DIVORCED *single*
(Write the word)

DATE OF DEATH *June 9, 1912*
(Month) (Day) (Year)

DATE OF BIRTH *June 2, 1912*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *6/2*, 191*2*, to *6/9*, 191*2*, that I last saw *her* or alive on *6/9*, 191*2*,

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

and that death occurred, on the date stated above, at *6 P.* m.
The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) _____

Infectious Convulsions

BIRTHPLACE (City or town, State or foreign country) *city*

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

NAME OF FATHER *Jacob Lubin*

(Signed) *J. J. ...* M. D. *6/10, 1912* (Address) *465 J. ...*

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

MAIDEN NAME OF MOTHER *Rose Kantor*

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

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) *Jacob Lubin*
(ADDRESS) *2109 N. Eleventh*

Former or usual residence _____

Filed **JUN 10 1912** 191*2* *Max B. Starkloff* REGISTRAR

PLACE OF BURIAL OR REMOVAL *Chest St. Emeth* DATE OF BURIAL *6/10, 1912*

UNDERTAKER *H. Berger* ADDRESS *2127 Carr*

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. WRITE IN PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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*, *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 "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Death" (of genital," "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 _____

Township _____

or

Village _____

or

City St. Louis

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 791File No. 21364Primary Registration District No. 1003Registered No. 5218(NO. 21694 Eleventh St. 3 Ward)

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

FULL NAME unnamed Rubin

PERSONAL AND STATISTICAL PARTICULARS

SEX

Fem.

COLOR OR RACE

WhiteSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

DATE OF BIRTH

June 2, 1912
(Month) (Day) (Year)

AGE

7 yrs. 7 mos. 7 ds.
IF LESS than
1 day, hrs. or min.

OCCUPATION

(a) Trade, profession, or particular kind of work None

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

BIRTHPLACE

(City or town, State or foreign country) City

NAME OF FATHER

Jacob Rubin

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Russia

MAIDEN NAME OF MOTHER

Rose Kantor

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Russia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Rubin(ADDRESS) 21694 Eleventh19111

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

6 9, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

6/3, 1912, to 6/9, 1912,that I last saw her alive on 6/9, 1912and that death occurred, on the date stated above, at 6/9

The CAUSE OF DEATH* was, as follows:

Infantile
Convulsions

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. 1 ds.

(Signed) _____

M. D. _____

1912 (Address) _____

*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

DATE OF BURIAL

Chapel Street Cemetery 6/10, 1912

UNDERTAKER

ADDRESS

H B Berger 2127 CassOriginal file, date 11/11

All information called for must be written on this Supplementary Certificate.

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.)