

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 St. Charles ✓
 County Portage Registration District No. 256 File No. 27304
 Township Mad. Primary Registration District No. 5899 Registered No. 9
 or
 Village _____ City _____ (NO. _____ St. _____ Ward _____)
 FULL NAME Roseau Theroff (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>Married</u>
DATE OF BIRTH <u>Not known</u> (Month) (Day) (Year)		
AGE <u>35</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>3-031</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Bulgaria</u>		
PARENTS	NAME OF FATHER <u>Not known</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Not known</u>	
	MAIDEN NAME OF MOTHER <u>Not known</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Not known</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 25th, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from St. Charles, 1912,
 that I last saw him alive on Aug 24th, 1912,
 and that death occurred, on the date stated above, at 11 P. m.
 The CAUSE OF DEATH* was as follows:
Accidental Drowning.
Fell from bridge while
swimming rocks.
W.D. (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. A. Thomas M. D. (Address) St. Charles
 *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 Aug 25, 1912
 UNDERTAKER Wellschlag-Decker ADDRESS St. Charles

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Amie Soloff
 (ADDRESS) _____
 Filed Aug 24, 1912 Frank S. Laidig REGISTRAR

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*, *peritonaeum*, 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.)



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PLACE OF DEATH

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

County St. Charles Registration District No. 756 File No. 27304
Township Portage des Sioux or Village _____ Primary Registration District No. 5997 Registered No. 9
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME: Toscan Thoroff

PERSONAL AND STATISTICAL PARTICULARS.

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE married
(MARRIED, WIDOWED, OR DIVORCED. Write the word)

DATE OF DEATH Aug. 23, 1912
(Month) (Day) (Year)

DATE OF BIRTH Not known
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept request, 1912, that I last saw h. Aug. 24, 1912 alive on _____ and that death occurred, on the date stated above, at 11 p. m.

AGE 35 yrs. _____ mos. _____ ds. -If LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:

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

Accidental drowning
Fell from barge while unloading rock
(Duration) _____ yrs. _____ mos. _____ ds.

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

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

PARENTS NAME OF FATHER _____ BIRTHPLACE OF FATHER _____ MAIDEN NAME OF MOTHER Not known BIRTHPLACE OF MOTHER _____

(Signed) N. G. F. Arnold, coroner M. D. Aug. 24, 1912 (Address) St. Charles

*State the Disease Causing Death, or, in deaths from Homicidal Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Suzie Swift

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

(ADDRESS) Fort Webster Camp 8

Where was disease contracted If not at place of death? Former or usual residence _____

Filed Nov 8 1912 Fossil Sautter REGISTRAR

PLACE OF BURIAL OR REMOVAL St. Charles City Camp DATE OF BURIAL Aug. 25 1912
UNDERTAKER W. Schaefer ADDRESS St. Charles

Original file, date AUG 24 1912 All information called for must be written on this Supplementary Certificate.

N. B. C.

Revised United States Standard Certificate of Death

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

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