

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.

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|-----------------------------------|--|----------------------------------------------------------------------------------------------|----------------------------|
| PLACE OF DEATH | | MISSOURI STATE BOARD OF HEALTH | |
| County <u>St. Louis</u> | | BUREAU OF VITAL STATISTICS | |
| Township <u>Central</u> | | Registration District No. <u>789</u> | File No. <u>27485</u> |
| Village _____ | | Primary Registration District No. <u>60380</u> | Registered No. <u>15-2</u> |
| City _____ | | (No. <u>1521 Lulu Ave</u> St. _____ | Ward _____ |
| FULL NAME <u>J. M. D. Audrain</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number] | |

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| SEX <u>Male</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR-DIVORCED (Write the word) <u>single</u> | DATE OF DEATH <u>Aug 20</u> 191 <u>2</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>July 10, 1912</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from <u>Aug 20</u> , 191 <u>2</u> , to <u>Aug 22</u> , 191 <u>2</u> , that I last saw him alive on <u>Aug 22</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>8 P.</u> m. | |
| AGE <u>6</u> yrs. <u>12</u> mos. <u>12</u> ds. | | IF LESS than 1 day, ___ hrs. or ___ min.? | The CAUSE OF DEATH* was as follows: <u>Diphtheria</u> | |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>At Home</u> | | | (Duration) ___ yrs. ___ mos. <u>3</u> ds. | |
| (b) General nature of industry, business, or establishment in which employed (or employer) <u>0</u> | | | Contributory _____ (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds. | |
| BIRTHPLACE (City or town, State or foreign country) <u>St. Louis Mo.</u> | | | (Signed) <u>John D. Poe</u> M. D. <u>8/20</u> 191 <u>2</u> (Address) <u>6131 Eastman</u> | |
| PARENTS | NAME OF FATHER <u>Pho. A. Audrain</u> | | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u> | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | |
| | MAIDEN NAME OF MOTHER <u>Maggie V. Revia</u> | | At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds. | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u> | | Where was disease contracted If not at place of death? _____ | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alphonse Audrain</u> | | | Former or usual residence _____ | |
| (ADDRESS) <u>Easton & Heights</u> | | | PLACE OF BURIAL OR REMOVAL <u>Salvator Cemetery</u> | |
| Filed <u>Aug 22</u> 191 <u>2</u> <u>Rolla Orsey</u> REGISTRAR | | | DATE OF BURIAL <u>Aug. 23, 1912</u> | |
| | | | ADDRESS <u>Geo. L. Hertoch 5984 Easton</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 Nomenclature of the American Medical Association.)

