

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City St. LouisRegistration District No. 791File No. 34794Primary Registration District No. 1003Registered No. 9176(No. 2317 Menard St. 9 Ward)

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

FULL NAME Gertrude S. Bequette

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)DATE OF BIRTH Aug. 6, 1910
(Month) (Day) (Year)AGE 1 yrs. 3 mos. 18 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) St. LouisPARENTS NAME OF FATHER Sain BequetteBIRTHPLACE OF FATHER (City or town, State or foreign country) mo.MAIDEN NAME OF MOTHER harmelia BoyerBIRTHPLACE OF MOTHER (City or town, State or foreign country) mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Bequette(ADDRESS) 2317 MenardFiled Oct 26 1912 1912 Max C. Starklof REGISTERAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 26, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Oct-20, 1912, to Oct-26, 1912 that I last saw h. w alive on Oct-25, 1912and that death occurred, on the date stated above, at 1:09 p.m.

The CAUSE OF DEATH* was as follows:

Convulsions
Irritation of central nervous system in brain mos. ____ ds.Contributory (Secondary) Lethargy (Duration) ____ yrs. ____ mos. ____ ds.(Signed) C. F. Keitredge M. D. Oct-26, 1912 (Address) 2806 S. Jefferson

*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 Old Mines Mo. DATE OF BURIAL Oct 27, 1912UNDERTAKER Walter Abelder ADDRESS 2331 S Broadway

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.

GORD

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*, *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 "*Asithenia*," "*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.)

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____
Township _____
or
Village _____
or
City St. Louis (NO. 2317 Menard)

Registration District No. 791 File No. 34794
Primary Registration District No. 1003 Registered No. 9176

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

FULL NAME Gertrude G. Bequette

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(If write the word)
DATE OF BIRTH Aug. 6, 1911
(Month) (Day) (Year)
AGE 1 yrs. 3 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Oct. 26, 1912
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from Oct. 25, 1912, to Oct. 26, 1912, that I last saw her alive on Oct. 25, 1912, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

convulsions

BIRTHPLACE (City or town, State or foreign country) St. Louis, Mo.

(Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER Sam Bequette

Contributory Rachitis
(SECONDARY)

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.

(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) C. F. Kuttredge M. D.
Oct. 26, 1912 (Address) 2806 D. Jefferson Ave.

MAIDEN NAME OF MOTHER Corbelle Boyer

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

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 (Informant) Sam Bequette

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

Former or usual residence. _____

(ADDRESS) 2317 Menard

PLACE OF BURIAL OR REMOVAL Old Mines, Mo. DATE OF BURIAL Oct. 27, 1912

Filed 12-27-12 1912 G. M. Sueder DEPUTY REGISTRAR

UNDERTAKER Wacker, Helderle ADDRESS 2331 D. Broadway

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SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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