

ALL UNPAID 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

Registration District No. 791

File No. 7561

Primary Registration District No. 1003

Registered No. 1217

No. City Hospital

St. 98 Ward

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

FULL NAME

M. V. Schindler

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Unknown, 1876
(Month) (Day) (Year)

AGE 36 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Salesman

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

BIRTHPLACE (City or town, State or foreign country) Mo. 4030

NAME OF FATHER Mathias Schindler

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

MAIDEN NAME OF MOTHER Glentz

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) FD Gurlong

(ADDRESS) Coroner Office

Filed FEB 25 1913 by Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 22, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at 3:20 m.

The CAUSE OF DEATH* was as follows:

Investigation Pending
163 M
(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) FD Gurlong M.D. 225 1913 (Address) Deputy Coroner

*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 Hamilton Hotel

PLACE OF BURIAL OR REMOVAL Bellefontaine DATE OF BURIAL Feb. 25, 1913

UNDERTAKER a. Ellis ADDRESS 727 N. Kingsway

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, 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," "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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

County _____

Township _____ or Village _____ or City St. Louis (NO. City Hospital St. _____ Ward _____)

Registration District No. _____ File No. 7561

Primary Registration District No. _____ Registered No. _____

FULL NAME

M. V. Schindler (Schindler)

[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 _____ COLOR OR RACE _____ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH 2-22- 1913
(Month) (Day) (Year)

DATE OF BIRTH _____, 19____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw h _____ alive on _____, 19____

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

and that death occurred, on the date stated above, at 3:30 P. m.

OCCUPATION (a) Trade, profession, or particular kind of work _____

The CAUSE OF DEATH* was as follows:

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

Investigation finding Hydrocyanide Acids Poisoning.

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

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

NAME OF FATHER _____

(Signed) J.P. Hurlong M.D.
6/24 1913 (Address) Deputy Coroner

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

MAIDEN NAME OF MOTHER _____

*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 MOTHER (City or town, State or foreign country) _____

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) _____

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

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 19____

Filed _____, 19____

UNDERTAKER _____ ADDRESS _____

REGISTRAR

Original file, date _____, 19____ All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

7 S. Parkway Bldg. Corner

Revised United States Standard Certificate of Death

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

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