

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. Louis  
 County St. Louis Registration District No. 1123 File No. 17657  
 Township Carondelet Primary Registration District No. 6248B Registered No. 222  
 or Village Koch Mo.  
 or City (NO. Robt. Koch Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ben F. Shepherd

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <b>Male</b>	COLOR OR RACE <b>White</b>	SINGLE MARRIED WIDOWED OR DIVORCED <b>Single</b> <small>(Write the word)</small>
DATE OF BIRTH <b>July 18, 1864</b> <small>(Month) (Day) (Year)</small>		
AGE <b>48 yrs. 9 mos. 26d.</b>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <b>Laborer</b> (b) General nature of industry, business, or establishment in which employed (or employer) <b>3-07</b>		
BIRTHPLACE (City or town, State or foreign country) <b>St. Louis</b>		
PARENTS	NAME OF FATHER <b>Thos. J. Shepherd</b>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <b>Kentucky</b>	
	MAIDEN NAME OF MOTHER <b>Mary J. Shepherd</b>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <b>Virginia.</b>	

**MEDICAL CERTIFICATE OF DEATH.**

DATE OF DEATH **May 14, 1913**  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from **May 8th**, 1913, to **May 14**, 1913, that I last saw him alive on **May 14**, 1913, and that death occurred, on the date stated above, at **9:10 P.** m.

The CAUSE OF DEATH\* was as follows:  
**Tuberculosis of the Lungs**

**2,3A**

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *A. J. Dwyer* M. D.  
**May 15**, 1913 (Address) **Koch Mo**

\*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 **1** yrs. **17** ds. In the State **49** yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? **St. Louis**

Former or usual residence **2720 Wood ST.**

PLACE OF BURIAL OR REMOVAL <b>Concordia Cemetery</b>	DATE OF BURIAL <b>May 16, 1913</b>
UNDERTAKER <b>Mullen W. Lee</b>	ADDRESS <b>2407 Lokenman St</b>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Hospital Records**  
(ADDRESS) **Koch Mo.**

Filed **MAY 15 1913** *L. C. Brock* 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 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 "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 septicæmia," "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 St. Louis  
 Township Barondelet  
 or Village Koch, Mo  
 or City \_\_\_\_\_ (NO. \_\_\_\_\_)

Registration District No. 1123 File No. 222  
 Primary Registration District No. 6248B Registered No. 222  
 (NO. Robt Koch Hospital Ward)

FULL NAME Benjamin <sup>Don't Know</sup> Shepherd (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  
 Satisfactory Information Supplied.

DATE OF DEATH May 14, 1913  
 (Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
 Satisfactory Information Supplied.

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 Satisfactory Information Supplied.

The CAUSE OF DEATH\* was as follows:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

PARENTS  
 NAME OF FATHER \_\_\_\_\_  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
 MAIDEN NAME OF MOTHER Not known  
 BIRTHPLACE OF MOTHER Virginia

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) \_\_\_\_\_ M. D. \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Robt. Koch Hospital Recorder  
 (ADDRESS) Koch, Mo

\*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 \_\_\_\_\_

Filed JUL 5 1913 1913 L. O. Brooks REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ Satisfactory Information Supplied.

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.

SUPPLEMENTARY

Satisfactory Information Supplied.

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