

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

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City Jefferson (NO. _____)

Registration District No. 701

File No. 24306

Primary Registration District No. 1003

Registered No. 6122

City Jefferson (NO. _____) St. 8 Ward

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

FULL NAME Peter Garich

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 July 3, 1913
(Month) (Day) (Year)

DATE OF BIRTH Nov 2, 1854
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 2, 1913, to July 3, 1913, that I last saw him alive on July 3, 1913

AGE 59 yrs. 0 mos. 0 ds. If LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 10 P m.

OCCUPATION (a) Trade, profession, or particular kind of work Peter's...

The CAUSE OF DEATH* was as follows:

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

Chronic Nephritis

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

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

NAME OF FATHER Nov...

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

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

(Signed) Frederic Taylor M.D. (Address) City Hospital

MAIDEN NAME OF MOTHER Nov...

*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) Nov...

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. ___ ds. In the ___ yrs. ___ mos. ___ ds.

(Informant) Ed...

Where was disease contracted if not at place of death?

(ADDRESS) City Hospital

Former or usual residence 1430 A B

FILED JUL -5 1913 Mac C Starkloff REGISTRAR

PLACE OF BURIAL OR REMOVAL Peter & Paul DATE OF BURIAL July 5, 1913

UNDERTAKER Petty Bros ADDRESS 2710 Lafayette av.

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.

B. Bud

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*, *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

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. 791File No. 24306Primary Registration District No. 1003Registered No. 6132

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

FULL NAME Peter Garrick

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MaleCOLOR OR RACE WhiteSINGLE MARRIED WIDOWED OR DIVORCED (Write the word) MarriedDATE OF DEATH July 3, 1913

(Month) (Day) (Year)

DATE OF BIRTH Not known, 1854

(Month) (Day) (Year)

AGE 59 yrs. ___ mos. ___ ds.

IF LESS than 1 day, ___ hrs. or ___ min.

I HEREBY CERTIFY, that I attended deceased from July 3, 1913, to July 3, 1913, that I last saw him alive on 7-3, 1913, and that death occurred, on the date stated above, at 5:00 p. m.

The CAUSE OF DEATH* was as follows:

OCCUPATION

(a) Trade, profession, or particular kind of work Porter(b) General nature of industry, business, or establishment in which employed (or employer) Drug Store

BIRTHPLACE

(City or town, State or foreign country) Bosnia AustriaNAME OF FATHER GarrickBIRTHPLACE OF FATHER (City or town, State or foreign country) Bosnia AustriaMAIDEN NAME OF MOTHER Smigajna PetrovichBIRTHPLACE OF MOTHER (City or town, State or foreign country) Bosnia Austria

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph J. Starbloff(ADDRESS) 2901 Minnesota Ave, St. Louis, MoFILED 9 1914

REGISTRAR

Contributory (SECONDARY)

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

(Signed) _____

(Address) _____

*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 _____ 1913

UNDERTAKER

ADDRESS _____

Original file, date July 5, 19141914

Information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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