

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

PLAGE OF DEATH
County St Louis

Township _____
or
Village _____
or
City Kirkwood (No 340 Van Buren)

Registration District No. 785
Primary Registration District No. 3037

File No. 27614
Registered No. 141

St. 2 Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Aliza Bailey

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE Col. SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH June 21, 1850
(Month) (Day) (Year)

AGE 63 yrs. 1 mos. 25 ds.
If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) O-O

BIRTHPLACE
(City or town, State or foreign country) Boonville Mo

PARENTS
NAME OF FATHER Harrison Prestor
BIRTHPLACE OF FATHER (City or town, State or foreign country) Booneville Mo
MAIDEN NAME OF MOTHER E. Alberte
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Booneville Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Alberte
(ADDRESS) Kirkwood Mo

Filed 8-19 1913 CA Summarau
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 16, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 15, 1913, to Aug 16, 1913, that I last saw h. er alive on Aug 16, 1913 and that death occurred, on the date stated above, at 9:30pm.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
92 D
72 D
97 (Duration) ___ yrs. ___ mos. 3 ds.
Contributory hypertension
(SECONDARY) (Duration) ___ yrs. several mos. ___ ds.
(Signed) M. J. Wynn M. D.
(Address) Jarviswood 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 ___ 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 Quinette Cemetery DATE OF BURIAL Aug. 19 1913
UNDERTAKER Louis H Bopp ADDRESS Kirkwood Mo

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.

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 "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.)

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

PLACE OF DEATH
 County St. Louis
 Township _____
 or
 Village _____
 or
 City Kirkwood

Registration District No. 785 File No. _____
 Primary Registration District No. 3037 Registered No. 141
 St. _____ Ward _____

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

FULL NAME Eliza Bailey

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF DEATH July 16, 1913
(Month) (Day) (Year)

DATE OF BIRTH Satisfactory (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above _____ m. The CAUSE OF DEATH* was as follows:
Central Hemorrhage

AGE _____ yrs. _____ mos. _____ days _____ hrs. _____ min. IF LESS than 1 day

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

Contributory Arterio sclerosis
(Brooklyn) (Duration) _____ yrs. _____ mos. _____ ds.
Levee
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) 8-17-13 (Address) Kirkwood Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (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 _____

Filed 10/14/13 1913 6 A. Dimmora
 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
 UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.
 SUPPLEMENTARY INFORMATION SUPPLIED

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