

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**

V

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City St. Louis (NO. 1625 Menard St.; 8 Ward)

Registration District No. 791

File No. 40673

Primary Registration District No. 1003

Registered No. 10638

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

FULL NAME Homer Edward Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Nov 30
(Month) (Day) (Year) 1913

DATE OF BIRTH April 1, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 10, 1913, to Nov 29, 1913, that I last saw him alive on Nov 29 (11 PM), 1913, and that death occurred, on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:
Bronchopneumonia
10 2 1/2 16 Days
106 C

AGE 7 yrs. 2 mos. 29 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) _____

(Duration) _____ yrs. _____ mos. 16 ds.

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

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

NAME OF FATHER Charles Thompson

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

MAIDEN NAME OF MOTHER Moley Fry

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

(Signed) H. Shore M. D.
Nov 30, 1913 (Address) 1344 S. Broadway

* 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Thompson

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

(ADDRESS) 1625 Menard St.

PLACE OF BURIAL OR REMOVAL St. Peter and Paul DATE OF BURIAL Dec 1, 1913

Filed DEC - 2 1913 Max Starkloff REGISTERED

UNDERTAKER Bloember and Sons ADDRESS 3163 S. Grand Ave

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 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.)

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

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

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

Registration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 10638(NO. 1625 Meunier)

St. _____

Ward) _____

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

FULL NAME Homer Edward Thompson

PERSONAL AND STATISTICAL PARTICULARS

SEX MCOLOR OR RACE W

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) S

DATE OF BIRTH _____

(Month) _____

(Day) _____

(Year) _____

AGE _____

If LESS than
1 day, ___ hrs
or ___ min

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 _____

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed 11/13 1913

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11-30 1913

(Month) _____

(Day) _____

(Year) _____

I HEREBY CERTIFY, that I attended deceased from 11-29, 1913, to 11-29, 1913, that I last saw him alive on 11-29, 1913, and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows: Broncho pneumonia16 daysAcute

(Duration) _____

yrs. _____

mos. 16

ds. _____

Contributory Bronchitis

(Secondary)

(Duration) _____

yrs. _____

mos. _____

ds. _____

(Signed) H. Shaw

M. D.

11/30 1913(Address) 1344 S. Broadway

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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 DEC - 1913

All information called for must be written on this Supplementary Certificate.

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.

Satisfactory Information Supplied.
SUPPLEMENTARY INFORMATION SUPPLIED.

Revised United States Standard Certificate of Death

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

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40673

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