

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

PLACE OF DEATH

County _____

Township _____

or Village _____

or City St. Louis MO (NO. 4039^c Swan av. St.: 25 Ward)

Registration District No. 791

Primary Registration District No. 1003

File No. 41836

Registered No. 12348

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

FULL NAME Flora A. Taylor

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb. 24, 1913
(Month) (Day) (Year)

DATE OF BIRTH Feb. 3, 1884
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 3, 1913, to Dec 24, 1913, that I last saw her alive on Dec 23, 1913, and that death occurred, on the date stated above, at 5/11 m.

AGE 29 yrs. 10 mos. 21 ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:

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

Pneumonia (Lobar)

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

10 1/2 (Duration) yrs. mos. ds.

NAME OF FATHER Jm Thornton

Contributory Abcess in Lobe
(SECONDARY)

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

(Duration) yrs. mos. ds.

MAIDEN NAME OF MOTHER Helen Menzie

(Signed) A. W. Fleming M. D.
Dec 26, 1913 (Address) 922 S. Vandeventer

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

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.

(ADDRESS) 4039^c Swan av

PLACE OF BURIAL OR REMOVAL Talkall DATE OF BURIAL 12/26, 1913

Filed Dec 26 1913 Marb Stackhoff REGISTRAR

UNDERTAKER Jm Armstrong ADDRESS 4234 M

N. B.—Every item of information should be carefully supplied. AGE should be stated ACTUALLY. 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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty _____
Township _____ or Village _____ or City St. Louis (NO. 4539 a swanan St. 25 Ward) Registration District No. 791 File No. _____Primary Registration District No. 1003 Registered No. 11348
FULL NAME Hora a Taylor (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED m (Write the word)DATE OF BIRTH _____, 1913
(Month) (Day) (Year)

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

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) _____

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 17361 1913 3 9 6 3 14 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH DEC 24, 1913
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from _____, 1913, to 12/24, 1913that I last saw her alive on 12/23, 1913and that death occurred, on the date stated above, at 5 P. m.The CAUSE OF DEATH* was as follows: Pneumonia (Lobar)

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

Contributory Access to lake
(SECONDARY) swimming
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) 1736 1913 (Address) 922 Standard M. D.

*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 DEC - 1913 19. All 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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