

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

PLACE OF DEATH

County Jefferson  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Desoto MO (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 420  
Primary Registration District No. 3022

File No. 1507  
Registered No. 10

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

FULL NAME Bertha May Rogers

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(If the word)

DATE OF BIRTH Aug 7, 1895  
(Month) (Day) (Year)

AGE 18 yrs. 5 mos. 17 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Jefferson Co

NAME OF FATHER John Rogers

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

MAIDEN NAME OF MOTHER Cisciro Woods

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Rogers  
(ADDRESS) Desoto MO

Filed 1/24, 1914 by Elma Kempe  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 24, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 22, 1914, to Jan 24, 1914, that I last saw her alive on Jan 24, 1914,

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

The CAUSE OF DEATH\* was as follows:  
23 Brain Abscess

7  
11 1/2  
(Duration) yrs. mos. ds.

Contributory La Grippe Pneumonia  
(SECONDARY) (Duration) yrs. mos. ds. 3 days

(Signed) F. E. Skinner M. D.  
Jan 24, 1914 (Address) Desoto 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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Desoto Cemetery DATE OF BURIAL 1-25-1914

UNDERTAKER Desoto Undert Co ADDRESS Desoto 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 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Jefferson

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

Township \_\_\_\_\_

Registration District No. 420

File No. \_\_\_\_\_

Village \_\_\_\_\_

Primary Registration District No. 3022

Registered No. 10

City St. Louis Mo. (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME

Berta May Rogers

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W SINGLE S MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ OR DIVORCED \_\_\_\_\_ (Write the word)

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 24, 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_.  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_.

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

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

Brain abscess  
Tuberculous

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

30 (Duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. Contributory La Grippe & Measles (SECONDARY)

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) \_\_\_\_\_

(Signed) J. E. Skinner M. D. Jan 24, 1914 (Address) St. Louis Mo.

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THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

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

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Where was disease contracted If not at place of death? \_\_\_\_\_ Former or usual residence \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

Filed 3/4-1914 191\_\_\_\_ Registrar J. E. Skinner

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

SUPPLEMENTARY INFORMATION supplied.

# Revised United States Standard Certificate of Death

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

1951

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