

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.

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

PLACE OF DEATH

County _____

Township _____

Village _____

City St Louis

Registration District No. 791

Primary Registration District No. 1003

(NO. 5230² Cote Brilliant av St. No Ward)

File No. 2522

Registered No. 89

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

FULL NAME James Dolan

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH January 3rd, 1914
(Month) (Day) (Year)

DATE OF BIRTH Nov 11, 1856
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from December 31, 1913, to January 3, 1914 that I last saw him alive on Dec 30, 1913 and that death occurred, on the date stated above, at 6⁴⁵ m.

AGE 56 yrs. 1 mos. 22 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Septicemia with Organic Disease of Heart and Liver
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OCCUPATION (a) Trade, profession, or particular kind of work Retail Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)

9th (Duration) 1 yrs. ___ mos. ___ ds.

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

Contributory (SECONDARY)

NAME OF FATHER Thomas Dolan

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

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

Signed: Robert J. O'Reilly M. D.
Jan 3 1914 (Address) 1023 N. Grand St.

MAIDEN NAME OF MOTHER Bridget Warren

*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) Ireland

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 State ___ yrs. ___ mos. ___ ds.

(Informant) John J. Dolan
(ADDRESS) 5230² Cote Brilliant av

Where was disease contracted if not at place of death?

Former or usual residence

Filed Jan -4 1914 Max C. Starkloff
REGISTRAR

PLACE OF BURIAL OR REMOVAL Cabary DATE OF BURIAL 1-5, 1914

UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St

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) *Colton 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 suicidè*. 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

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

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

County _____

Township _____

or Village _____

or City **ST. LOUIS**

Registration District No. 791

File No. _____

Primary Registration District No. 1003

Registered No. 89

(No. 5230 2601, Milliant Ave. 26 Ward)

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

FULL NAME

James Dolan

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
Satisfactory Information Supplied.

DATE OF BIRTH _____, 19____
(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) _____

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
Satisfactory Information Supplied.
(Informant) _____
(ADDRESS) _____

Filed 3-3- 1914 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 3, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above at _____ m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis with Organic disease of heart and liver with Mutual insufficiency.

Contributory _____ (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Roberts J. O'Reilly M.D. (Address) 1023 Spr. Grand St.

*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 _____ 19____

UNDERTAKER _____ Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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