

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

PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

Village \_\_\_\_\_

City St. Louis (NO. 3517 Market St. 16 Ward)

Registration District No. 791

Primary Registration District No. 1008

File No. 2724

Registered No. 304

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

FULL NAME Mollie E. Harmer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Jan 8, 1914  
(Month) (Day) (Year)

DATE OF BIRTH Jan 5, 1882  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 3, 1913, to July 8, 1914  
that I last saw her alive on July 2, 1914

AGE 32 yrs. 3 mos. 3 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

and that death occurred, on the date stated above, at 10<sup>45</sup> m.

OCCUPATION (a) Trade, profession, or particular kind of work Housework

The CAUSE OF DEATH\* was as follows:  
131 39 Nephritis

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

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

Contributory Chronic Malara  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

NAME OF FATHER William T. Lewis

(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

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

(Signed) Wm. E. Barker M. D.  
1914 (Address) St. Louis

MAIDEN NAME OF MOTHER Mary E. Woodcock

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) Missouri

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

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

(Informant) William E. Harmer

PLACE OF BURIAL OR REMOVAL St. Louis DATE OF BURIAL

(ADDRESS) 3517 Market

UNDERTAKER Wm. E. Barker ADDRESS

Filed JAN - 9 1914 Wm. E. Barker REGISTRAR

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*, *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*, *peritonaeum*, 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 septichaemia," "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

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

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City ST. LOUISRegistration District No. 791

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

Primary Registration District No. 1003Registered No. 304(No. 3517 Market)St. 16 Ward)

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

FULL NAME Mollie C. Harmer

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX \_\_\_\_\_

COLOR OR RACE \_\_\_\_\_

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH

Jan 8, 1914

(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_

(Month) (Day) (Year)

AGE \_\_\_\_\_

If LESS than  
1 day, \_\_\_\_\_ hrs  
or \_\_\_\_\_ min

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, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Nephritis (Chronic)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Contracted by Chronic Malaria(SECONDARY) (Duration) 12 months yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.(Signed) Frank B. [unclear] M. D.J/26 1914 (Address) Highland

\*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. \_\_\_\_\_ da. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

\_\_\_\_\_ 191\_\_\_\_

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

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

Filed 2-28 1914

REGISTRAR

Original file, date JAN - - 1914, 19\_\_\_\_ All information called for must be written on this Supplementary Certificate.

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