

## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City St Louis

Registration District No. \_\_\_\_\_

791

File No.

3050

Primary Registration District No. \_\_\_\_\_

1003

Registered No.

644

(NO. \_\_\_\_\_)

2509 Davison Place St. M Ward

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

## FULL NAME

Mary Humpert

## PERSONAL AND STATISTICAL PARTICULARS

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

## DATE OF BIRTH

Jan (Month) 16<sup>th</sup> (Day) 1853 (Year)

## AGE

60 yrs. - mos. - ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

## OCCUPATION

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

Housework

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

## BIRTHPLACE

(City or town, State or foreign country)

St Louis

NAME OF FATHER

Frederik Stieve

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Germany

MAIDEN NAME OF MOTHER

Gertrude Dreyer

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allys Humpert

(ADDRESS)

2509 Davison Place

Filed

JAN 18 1914

Max Starkloff  
REGISTERARMISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

## 2. MEDICAL CERTIFICATE OF DEATH

## DATE OF DEATH

Jan (Month) 16<sup>th</sup> (Day) 1914 (Year)I HEREBY CERTIFY, that I attended deceased from Aug. 15<sup>th</sup>, 1913, to Jan 16<sup>th</sup>, 1914, that I last saw her alive on Jan 15, 1914, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

Mitral Insufficiency

92A

136A

(Duration) 5 yrs. - mos. - ds.

Contributory

(SECONDARY)

Bronchitis(Duration) 1 yrs. - mos. - ds.

(Signed)

P. P. Meserve M. D.Jan 16, 1914 (Address) 2356 Geraldine

\*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

Calvary Cem.

DATE OF BURIAL

Jan 19<sup>th</sup>, 1914

UNDERTAKER

Edward Koch

ADDRESS

3576 N 14<sup>th</sup>

AGE should be stated EXACTLY. PHYSICIAN'S name should be properly classified. Exact statement of OCCUPATION is very important.

# 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, 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 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

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

County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City ST. LOUIS  
 Registration District No. 791 File No. \_\_\_\_\_  
 Primary Registration District No. 1003 Registered No. 644  
 (NO. 2509 Davison Pl St. 24 Ward)

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

FULL NAME Mary Humpert

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)  
 DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_ (Month) (Day) (Year)  
 AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs \_\_\_\_\_ or \_\_\_\_\_ min \_\_\_\_\_  
 mos. \_\_\_\_\_ ds.

DATE OF DEATH January 16, 1914  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

The CAUSE OF DEATH\* was as follows: Mital Insufficiency

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

Contributory Pneumonia (Acute)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) R. R. Menoun M. D.  
Jan 17, 1914 (Address) 2356 Geraldine

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) \_\_\_\_\_

\*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 \_\_\_\_\_

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

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

Filed 3-3 1914 H. G. Snyder REGISTRAR

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it can be classified. Each statement of OCCUPATION should be carefully supplied. Each statement of OCCUPATION should be carefully supplied.

Satisfactory information supplied.  
 Satisfactory information supplied.  
 Satisfactory information supplied.  
 Satisfactory information supplied.

Satisfactory information supplied.

# Revised United States Standard Certificate of Death

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

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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.)

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