

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. 791

File No. 3313

Primary Registration District No. 1003

Registered No. 922

(NO. 1320 Barrow aven St. Ward)

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

FULL NAME Fidelia Woods

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Negro SINGLE MARRIED Child WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH 1/25, 1914
(Month) (Day) (Year)

DATE OF BIRTH Dec. 9, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1/19, 1914, to 1/25, 1914, that I last saw her alive on 1/25, 1914, and that death occurred, on the date stated above, at 70 m. The CAUSE OF DEATH* was as follows:

AGE 1 yrs. 4 mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.?

106A Bronchitis
(Duration) _____ yrs. _____ mos. 9 ds.

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

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

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

(Signed) Wm. G. Wood M.D. - M. D.
1/26, 1914 (Address) 5855 Manchester

NAME OF FATHER Wm Woods

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

MAIDEN NAME OF MOTHER Phoda Taylor

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

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Wm Woods

Where was disease contracted If not at place of death?

Former or usual residence

(ADDRESS) 1320 Barrow Ave

PLACE OF BURIAL OR REMOVAL Greenwood DATE OF BURIAL 1/26, 1914

Filed JAN 26 1914 Marble Starkloff REGISTRAR

UNDERTAKER C. Russell ADDRESS 2732 Pine St

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*, *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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____
 Township _____ or Village _____ or City ST. LOUIS
 Registration District No. 977991 File No. _____
 Primary Registration District No. 1003 Registered No. 922
 (NO. 1320 Barron Ave St. 24 Ward)

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

FULL NAME Lucelia Woods

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____ SINGLE MARRIED WIDOWED OR DIVORCED
 Satisfactory information supplied.

DATE OF DEATH July 25, 1914
 (Month) (Day) (Year)

DATE OF BIRTH _____
 (Month) (Day) (Year)
 Satisfactory information supplied.

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____,

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

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

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

The CAUSE OF DEATH* was as follows:

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

Bronchitis (Acute)

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

(Duration) _____ yrs. _____ mos. 9 ds.

NAME OF FATHER _____

Contributory (SECONDARY) _____

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

(Signed) R. M. G. Wood M. D.

MAIDEN NAME OF MOTHER _____

2/26, 1914 (Address) 7334 Manchester

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

*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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 191____

Filed 2-28, 1914 R. M. G. Wood REGISTRAR

UNDERTAKER _____

ADDRESS _____

Original file, date JAN - -1914

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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