

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF DEATH

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

County \_\_\_\_\_

Township \_\_\_\_\_

Registration District No. **791**

File No. **6265**

Village \_\_\_\_\_

Primary Registration District No. **1003**

Registered No. **1323**

City **St. Louis** (NO. **Centenary Hosp** St. **17** Ward)

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

FULL NAME **Josephine E. Gunn**

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 **Feb 6, 1914**  
(Month) (Day) (Year)

DATE OF BIRTH **Oct 14, 1886**  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from **Feb 3, 1914**, to **Feb 6, 1914**, that I last saw her alive on **Feb 6, 1914**, and that death occurred, on the date stated above, at **7 p. m.**

AGE **27 yrs. 3 mos. 23 ds.** IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
**Operation for post-operative obstruction of Duodenum. Cholerae.**

OCCUPATION (a) Trade, profession, or particular kind of work **Housewife** (b) General nature of industry, business, or establishment in which employed (or employer) **101**

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. **2** ds.

BIRTHPLACE (City or town, State or foreign country) **Verailles Mo**

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

NAME OF FATHER **C. W. Burroch**

(Signed) **A. D. Kieffer** M. D. **Feb 6, 1914** (Address) **4480 Westminster**

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

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER **Sue Lempee**

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) **Verailles Mo**

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. **3** ds. In the State **27** yrs. **3** mos. **23** ds. Where was disease contracted if not at place of death?

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Former or usual residence **Verailles Mo**

(Informant) **A. D. Kieffer** (ADDRESS) **4480 Westminster**

PLACE OF BURIAL OR REMOVAL **Verailles Mo** DATE OF BURIAL **2-8** 1914

Filed **Max C. Starkloff** REGISTRAR

UNBERTAKER **Wattman & Sons** ADDRESS **1024 Pendleton**

# 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*, *Sar-*

*coma*, 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.)



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

PLACE OF DEATH

County \_\_\_\_\_  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City St. Louis (NO. Outenry Hosp St. 17 Ward)

Registration District No. 791  
Primary Registration District No. 1003

File No. \_\_\_\_\_  
Registered No. 1323

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

FULL NAME

Josephine E. Lewis

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M  
(Write the word)

DATE OF DEATH Feb - 6, 1914  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_  
(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 7 P. m.

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

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) \_\_\_\_\_

Operation for foot operation  
Obstruction of vessels from cholid  
leus by enlarged lymphatic gland  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

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

Contributory (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) A. P. Metzger M. D.  
716, 1914 (Address) 4480 Metairie

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) \_\_\_\_\_

\*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 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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 7-6 1914 A. P. Metzger REGISTRAR  
4-30

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

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