

WHILE FADING 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.

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

PLACE OF DEATH _____

County _____

Township _____

or Village _____

or City St Louis (NO. _____)

Registration District No. 1008

Primary Registration District No. _____

City St Louis (NO. 3528⁴ S Jefferson)

File No. 10020

Registered No. 2121

Ward 10

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

FULL NAME Katherine Heilmann

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

DATE OF DEATH

Feb 28, 1914
(Month) (Day) (Year)

DATE OF BIRTH

Nov 20, 1874
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov, 1913, to Feb 28, 1914,

that I last saw h. alive on Feb 23, 1914,

and that death occurred, on the date stated above, at 6:40 a.m.

AGE

89 yrs. 2 mos. 8 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

Arteria plevorica

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

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

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97

BIRTHPLACE

(City or town, State or foreign country) Germany

(Duration) yrs. 4 mos. ds.

Contributory

(SECONDARY)

(Duration) yrs. ___ mos. 7 ds.

PARENTS

NAME OF FATHER

Unknown Germany

BIRTHPLACE OF FATHER

Germany

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER

Germany

(Signed) H. J. B. Arnold M. D.

March 1st, 1914 (Address) 2407 S. 8th

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Guse

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) 3528⁴ S. Jefferson

PLACE OF BURIAL OR REMOVAL

Concordia Cemetery

DATE OF BURIAL

March 2nd, 1914

Filed

MAR -2 1914 Max Starkloff

UNDERTAKER

Swepthrup & Sons

ADDRESS

603 Park Ave

REGISTERED

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*, *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 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.

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. 2121
(No. 3528^a St. Jefferson St.; 10 Ward)

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

FULL NAME Katharine Hellmann

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 28 1914
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____
Satisfactory Information Supplied. 1914
that I last saw h _____ alive on _____, 1914
and that death occurred, on the date stated above, at 10¹⁵ a.m.

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

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

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) _____

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

NAME OF FATHER _____

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

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

(Signed) A. J. Karnisch M. D.
371 (Address) 2407 S. 18th

MAIDEN NAME OF MOTHER _____

*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) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ 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 _____

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1914

Filed 3/7 1914 A. G. L. Medgar REGISTRAR
5-9

UNDERTAKER _____ ADDRESS _____

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Satisfactory Information Supplied.
SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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10020

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