

Information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be stated EXACTLY. If 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 Moor (NO. St Anthony's Hospital St. 17 Ward)

Registration District No. 791

File No. 17602

Primary Registration District No. 1003

Registered No. 4795

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

FULL NAME Barbra Magda

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 19th, 1888
(Month) (Day) (Year)

AGE 31 yrs. 1 mos. 22 ds.
If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
NAME OF FATHER Peter Guldner
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Katie Fischer
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Magda
(ADDRESS) 4918 Kaiser St.

Filed May 12 1914 by W. B. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 11, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 2, 1914, to May 11, 1914, that I last saw her alive on May 11, 1914, and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Colangitis
126
127B (Duration) 2 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
Signed) Julius Freude M. D.
May 12 1914 (Address) 2521 1/2 Broadway

*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. 7 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
Former or usual residence 4918 Kaiser St

PLACE OF BURIAL OR REMOVAL Cremation DATE OF BURIAL May 13th, 1914

UNDERTAKER J. H. Hubben 2, 1110 2872 Meunier ADDRESS _____

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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

Registration District No. 791

File No. _____

Village _____

Primary Registration District No. 1003

Registered No. 4795

City St Louis (NO. _____ St. _____ Ward _____)

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

FULL NAME

Barbra Magda

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH May 11, 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 _____ m.

AGE _____
IF LESS than 1 day, _____ hrs _____ min _____ 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) _____

Colangitis
Cholecystitis & Cholelithiasis
(Duration) 3 yrs. _____ mos. _____ ds.

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

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

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) _____

(Signed) Julius J. ... D. _____
1914 (Address) _____

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

42-24 1914 9.4.3 Magda
REGISTRAR

MAY 1914

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH

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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