

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

18276

PLACE OF DEATH St. Louis
 County St. Louis Registration District No. 839 File No. _____
 Township Richmond Primary Registration District No. 6691 Registered No. 28
 or _____
 Village _____
 or _____
 City _____ (NO. _____ St.: _____ Ward _____)

FULL NAME John Wesley Grimes

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <input checked="" type="checkbox"/> WIDOWED OR DIVORCED (Write the word)	
DATE OF BIRTH <u>Apr 4</u> , 19 <u>14</u>		DATE OF DEATH <u>May 8</u> , 19 <u>14</u>	
(Month) (Day) (Year)		(Month) (Day) (Year)	
AGE <u>1</u> yrs. <u>4</u> mos. <u>4</u> ds.		I HEREBY CERTIFY, that I attended deceased from <u>May 7</u> , 19 <u>14</u> , to <u>his visit</u> , 19 <u>14</u> , that I last saw him alive on <u>May 7</u> , 19 <u>14</u> , and that death occurred, on the date stated above, at <u>10⁰⁰</u> a.m.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>L</u>		The CAUSE OF DEATH* was as follows: <u>Mastoiditis</u> <u>8912</u>	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>L</u>		(Duration) <u>L</u> yrs. <u>L</u> mos. <u>L</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Gray Ridge, Mo.</u>		Contributory (SECONDARY) <u>L</u>	
PARENTS	NAME OF FATHER <u>John Grimes</u>		(Signed) <u>J. P. Brandon</u> M. D.
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill.</u>		5-8 19 <u>14</u> (Address) <u>Residence</u>
	MAIDEN NAME OF MOTHER <u>Mary White</u>		* 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) <u>Mo.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>5</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>5</u> yrs. <u>0</u> mos. <u>0</u> ds.

DATE OF DEATH May 8, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 7, 1914, to his visit, 1914, that I last saw him alive on May 7, 1914, and that death occurred, on the date stated above, at 10⁰⁰ a.m.

The CAUSE OF DEATH* was as follows:
Mastoiditis
8912

(Duration) L yrs. L mos. L ds.

Contributory (SECONDARY) L

(Signed) J. P. Brandon M. D.
 5-8 1914 (Address) Residence

* 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 5 yrs. 0 mos. 0 ds. In the State 5 yrs. 0 mos. 0 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) John Grimes
 (ADDRESS) Gray Ridge
5711 1/2 W. Caldwell
 Filed 5/11, 1914 REGISTRAR

PLACE OF BURIAL OR REMOVAL St. Louis
 DATE OF BURIAL 5/10 1914
 UNDERTAKER None
 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*, *Composer*, *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, 8 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.)

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

PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St. Ward

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

M

W

S

May 8, 1914

(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Satisfactory Information Supplied.

AGE

IF LESS than
1 day, hrs. min.

that I last saw h. alive on

and that death occurred, on the date stated above,

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:

Mastoiditis
NO further history

BIRTHPLACE

(City or town, State or foreign country)

(Duration) yrs. mos. ds.

NAME OF FATHER

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

(Signed) J. P. Brandon M. D.

1914 (Address) Essex Mass

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)

Address of death yrs. mos. ds. In the State yrs. mos. ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Where was disease contracted If not at place of death?

Former or usual residence.

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filed

MAY 11 1914

J. C. Caldwell

REGISTRAR

UNDERTAKER

ADDRESS

Original file, date

All information called for must be written on this Supplementary Certificate.

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.

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

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18274
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.)