

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

23895

PLACE OF DEATH
County St. Louis
Township _____
or _____
Village _____
or _____
City Webster Groves, Mo.

Registration District No. 788 File No. _____
Primary Registration District No. 4471 Registered No. 56
(NO. 318 East Swann St.; _____ Ward)

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

FULL NAME Elizabeth A Lent

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE Caucasian white SINGLE MARRIED married
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH Nov 5th 1892
(Month) (Day) (Year)

AGE 81 yrs. 8 mos. 23 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) New York

PARENTS
NAME OF FATHER Walter Broughton
BIRTHPLACE OF FATHER (City or town, State or foreign country) New York
MAIDEN NAME OF MOTHER Lillie Cross
BIRTHPLACE OF MOTHER (City or town, State or foreign country) New York

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin H. Bush
(ADDRESS) Webster Groves, Mo.

Filed 7/29 1914 H. H. Delaney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 28, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1, 1912, to July 28, 1914, that I last saw her alive on July 28, 1914, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Nephritis
Paralysis
131
(Duration) 15 yrs. _____ mos. _____ ds.

Contributory Nephritis
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Howard Carter M. D.
July 29, 1914 (Address) Webster Groves

* 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 _____

PLACE OF BURIAL OR REMOVAL Oak Hill DATE OF BURIAL July 30, 1914
UNDERTAKER Parker and Co ADDRESS Webster Groves

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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County

St. Louis

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

788

File No.

Township

Registration District No.

or Village

Primary Registration District No.

Registered No.

or City

Robttsboro.

(No.)

St.

Ward)

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

FULL NAME

Elizabeth A. Lent

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OF RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

IF LESS than 1 day, hrs. min. 2 yrs. mos. ds.

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)

PARENTS

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

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REGISTRAR

I HEREBY CERTIFY, that I attended deceased from *St. Louis* 191*4*, to *St. Louis*, 191*4*, that I last saw h *St. Louis*, 191*4*, and that death occurred, on the date stated above, at *St. Louis* m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis
 (Duration) *120X* yrs. mos. ds.

Contributory (SECONDARY) *Nephritis*
 (Duration) yrs. mos. ds.

(Signed) *Robert J. ...* M. D.
 July 29, 1914 (Address) *Robttsboro*

*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

PLACE OF BURNING OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Satisfactory Information Supplied

Satisfactory Information Supplied

Original file, date

JUL 1914

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.

A DEPARTMENT WITH UNRECORDED INFO THIS IS A PERMANENT RECORD

Revised United States Standard Certificate of Death

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

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23896
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