

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

PLACE OF DEATH

County.....

Township.....

Registration District No.....

File No.....

24393

Village.....

Primary Registration District No.....

Registered No.....

6823

City *St Louis Mo* (NO. *3845 Hartford* St. *18* Ward)

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

FULL NAME *Norma H Green*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *Female* COLOR OR RACE *White* SINGLE MARRIED ~~WIDOWED~~ OR DIVORCED (If so, state) *Single*

DATE OF BIRTH *October 22, 1896*
(Month) (Day) (Year)

AGE *17* yrs. *8* mos. *23* ds. IF LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work: *Telephone Girl*
(b) General nature of industry, business, or establishment in which employed (or employer): *12211, 12212, 12213*

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

NAME OF FATHER *William Green*

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

MAIDEN NAME OF MOTHER *Anna Luzar*

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Wm Green*

(ADDRESS) *3845 Hartford*

Filed *JUL 16 1914* 191*4*

REGISTRAR

DATE OF DEATH *July 15, 1914*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *July 12, 1914*, to *July 15, 1914*, that I last saw her alive on *July 15, 1914*, and that death occurred, on the date stated above, at *10 a.m.*

The CAUSE OF DEATH* was as follows:

Peritonitis (abdominal) due to rupture of Stercoral abscess through wall of descending colon.
(Duration) yrs. mos. ds. *11*

Contributory *stercoral abscess of descending colon with rupture perforation due to accumulation of feces*
(Signed) *P. M. Duffell, M.D.*
17/15/14 (Address) *325 1/2 Frances Bld.*

*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 *2* yrs. mos. ds. In the State *17* yrs. *8* mos. *23* ds.

Where was disease contracted if not at place of death?

Former or usual residence *3845 Hartford*

PLACE OF BURIAL OR REMOVAL *New St Marcus*

DATE OF BURIAL *July 17, 1914*

UNDERTAKER *Gegenhein Bros* ADDRESS *2623 Cherokee*

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

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 septichaemia," "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 railroad 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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or _____

Village _____ Primary Registration District No. _____ Registered No. 6829or St. Louis (NO. 3845 Hartford St. 13 Ward)

City _____

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

FULL NAME Norma H. Green

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	DATE OF DEATH <u>July 15</u> , 191 <u>4</u> (Month) (Day) (Year)
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DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

Satisfactory Information Supplied.

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

that I last saw h. _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

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: _____

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) _____ M. D.

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

At place of death _____ yrs. _____ mos. _____ ds. In the State of _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

(ADDRESS) _____

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

Filed _____ 1914 G. E. Good REGISTRAR

UNDERTAKER _____ ADDRESS _____

Original file, date JUL 1914 19 _____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

24393

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