

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City St. Louis Mo.Registration District No. 791File No. 24412Primary Registration District No. 1003Registered No. 6845(NO. Missouri Baptist Santuary St. 73 Ward)

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

FULL NAME Hedvige Aurelia Schmitt

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)DATE OF DEATH July - 16 - 1914
(Month) (Day) (Year)DATE OF BIRTH July - 9 - 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from July - 9 - 16, 1914, to July - 15, 1914 that I last saw him alive on 15, 1914AGE _____ yrs. _____ mos. 7 ds. If LESS than 1 day, _____ hrs. or _____ min.?and that death occurred, on the date stated above, at 4:30 a.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) Missouri Baptist SantuaryCongestive
failure of the right heart.
69 (Duration) _____ yrs. 104 mos. _____ ds.Contributory
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.PARENTS
NAME OF FATHER Henry J. Schmitt
BIRTHPLACE OF FATHER
(City or town, State or foreign country) St. Louis Mo.(Signed) William J. Hays M. D.
7/17, 1914 (Address) 4532-1/2 Ave.Maiden Name of Mother Kathie Amelia Poppel
BIRTHPLACE OF MOTHER
(City or town, State or foreign country) St. Louis Mo.

* 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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) William J. Hays M.D.At place of death _____ yrs. _____ mos. 7 ds. In the State _____ yrs. _____ mos. 7 ds.(ADDRESS) 4532-1/2 Ave.

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

Former or usual residence 4707 NebraskaFiled Aug 17 1914

REGISTRAR

PLACE OF BURIAL OR REMOVAL St. Matthew DATE OF BURIAL July 17 1914
UNDERTAKER Julius J. Schmitt ADDRESS 1819 Sidney

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, 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

County _____

Township _____

or _____

Village _____

or _____

City St. Louis

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 DEATHRegistration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 6845(NO. Mo Baptist Sanitarium st. 23 Ward)

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

FULL NAME Kathryn Luccelia Schmidt

PERSONAL AND STATISTICAL PARTICULARS

SEX F COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)DATE OF BIRTH _____
(Month) _____ (Day) 1 (Year) _____
Satisfactory information supplied.AGE _____
If LESS than 1 day, _____ hrs. or _____ min.
_____ 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) _____

File _____ 191 4.4 Snodgrass REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 16, 1914
(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, and that I last saw him alive on _____, 191____.

The CAUSE OF DEATH* was as follows: _____

Contributory (SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 191____ (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 _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 191____

UNDERTAKER _____

ADDRESS _____

Original file, date _____

JUL

1914

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]

21742

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