

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

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City St Louis

Registration District No. 791

Primary Registration District No. 1003

(NO. Childrens Hospital St. 5 Ward)

File No. 27809

Registered No. 7843

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

FULL NAME Ernestine Maetlow

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m. COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED Infant (If write the word)

DATE OF DEATH August 17, 1914
(Month) (Day) (Year)

DATE OF BIRTH June 26, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from August 3, 1914, to August 17, 1914, that I last saw him alive on August 17, 1914, and that death occurred, on the date stated above, at 2⁴³ m.

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

The CAUSE OF DEATH* was as follows:
Alimentary Intoxication
117 A
119 B
(Duration) _____ yrs. _____ mos. _____ ds.

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

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

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

PARENTS NAME OF FATHER Will Mathew
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri
MAIDEN NAME OF MOTHER Viola Rainis
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Missouri

(Signed) P. S. Jones M. D.
Aug 17, 1914 (Address) 400 So Jefferson

*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 (Informant) E. Maetlow
(ADDRESS) 400 S. Jefferson

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. 14 ds. In the State _____ yrs. 2 mos. 22 ds.
Where was disease contracted if not at place of death? 1929 Clin. St.
Former or usual residence 1929 Olive St.

Filed Aug 18 1914 May Starkloff REGISTRAR

PLACE OF BURIAL OR REMOVAL Cabary DATE OF BURIAL 8-19, 1914
UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St

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.

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, meningis, peritoneum*, 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: *Medsles* (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 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

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

Village _____

City St. Louis (NO. _____)

Registration District No. 791

File No. _____

Primary Registration District No. 1003

Registered No. 7843

FULL NAME

Winston Matthew

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Infant (If wife deceased)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

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

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) _____

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 12-19 1914 H. G. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 17 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ to _____, 1914, that I last saw h. _____ alive on _____, 1914, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Alimentary Intoxication
"Cholera Infantum"
(Duration) _____ yrs. _____ mos. _____ ds.

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

PLACE OF BIRTH OR REMOVAL _____ DATE OF BURIAL _____ 1914

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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