

PLACE OF DEATH

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

County _____

Township _____

Registration District No. 701File No. 28044

Village _____

Primary Registration District No. 1003Registered No. 8110City St. Louis(NO. 3218 Dakota St. 13 Ward)

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

FULL NAME Jacob Polz

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(# wife the word)DATE OF BIRTH July 24, 1844
(Month) (Day) (Year)AGE 70 yrs. 1 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?OCCUPATION
(a) Trade, profession, or particular kind of work Retired - 4 yrs
(b) General nature of industry, business, or establishment in which employed (or employer) Saloon-keeperBIRTHPLACE Germany
(City or town, State or foreign country)NAME OF FATHER Don't knowBIRTHPLACE OF FATHER Don't know
(City or town, State or foreign country)MAIDEN NAME OF MOTHER Don't knowBIRTHPLACE OF MOTHER Don't know
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gus Polz(ADDRESS) 3218 Dakota St.Filed AUG 28 1914 Max Ostrowsky REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 26, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from May 1, 1914, to Aug 26, 1914, that I last saw him alive on Aug 26, 1914, and that death occurred, on the date stated above, at 8:30 p.m.The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
1234
131
71
(Duration) ___ yrs. 3 mos. 26 ds.Contributory Myocarditis Heart disease
(SECONDARY) (Duration) ___ yrs. 2 mos. ___ ds.(Signed) Wm. E. Holden M. D.
Aug 27, 1914 (Address) 4514 Virginia

*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 Missouri Crematory DATE OF BURIAL Aug 29, 1914UNDERTAKER W. E. Cohen & Co. ADDRESS 2842 Menomonee

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, 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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City St. Louis (NO. _____)Registration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 8110

St. _____ Ward _____

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

FULL NAME Jacob. Bolz.

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W. SINGLE Widowed
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH _____
 (Month) _____ (Day) 1 (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 12-23 1914 H. G. L. Moore REGISTRAR

AUG 4 1914

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 26 1914
 (Month) _____ (Day) _____ (Year) _____

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

and that death occurred, on the date _____ at _____ m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Chronic Nephritis Duration) _____ yrs. _____ mos. _____ ds.

Contributors Chronic Nephritis Duration) _____ yrs. _____ mos. _____ ds.

Chronic Nephritis Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Holleried M. D. July 27 1914 (Address) 4504 Virginia

*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 _____ 1914

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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