

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

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City St. Louis (NO. 2312nd North 11th St.: 3 Ward)

Registration District No. 781

File No. 30421

Primary Registration District No. 1008

Registered No. 8305

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

FULL NAME Julia C. Krebs

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF DEATH Sept 4, 1914
(Month) (Day) (Year)

DATE OF BIRTH Nov. 20, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 20th, 1914, to Sept 4, 1914, that I last saw her alive on Sept. 4th, 1914, and that death occurred, on the date stated above, at IND M.

AGE 9 yrs. 15 mos. 15 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Marasmus
119
158

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) Missouri

NAME OF FATHER Charles Krebs

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

MAIDEN NAME OF MOTHER Elise Gibson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Infantile

(Duration) yrs. mos. ds.

(Signed) S. J. Traub M. D.
9/4, 1914 (Address) 12th & 9th St. Louis

*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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. Krebs

(ADDRESS) 2312nd N-11th

PLACE OF BURIAL OR REMOVAL Calvary Cem. DATE OF BURIAL Sept. 5, 1914

UNDERTAKER Geo. Neumann 412 E. 11th St. Manhattan

Filed SEP -5 1914 Mayb Starkloff REGISTRAR

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.

Dr. E. J. Traublich
12 - St. Louis
Gen. 8528 P
7-8-PM

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.)

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 _____

Registration District No. 791

File No. _____

Village _____

Primary Registration District No. 1003Registered No. 8305City St. Louis(NO. 2312 a North 11 St. 3 Ward)

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

FULL NAME Julia E. Kribes

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MCOLOR OR RACE WSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) S

DATE OF DEATH

Sept 4, 1914
(Month) (Day) (Year)

DATE OF BIRTH

_____, 1_____, 1_____
(Month) (Day) (Year)

AGE

15 yrs. 15 ds. 15 hrs. 15 min.
If LESS than 1 day, _____ hrs. or _____ min.HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____, that I last saw him alive on _____, 191_____, and that death occurred, on the date stated above, at 1:15 m.

The CAUSE OF DEATH* was as follows:

ManusOCCUPATION
(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) _____Contributory Cholera Inf.

(SECONDARY)

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

(Signed) 9/4_____, 1914 (Address)

M. D.

*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 _____ mos. _____ ds. In the _____ 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 _____

File # Sept 5 1914REGISTRAR rep

SEP - 1914

Original file, date _____, 19____

All information called for must be written on this Supplementary Certificate.

Exact statement of OCCUPATION is very important.

Satisfactory Information Supplied

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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