

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City St. LouisRegistration District No. 701 1008File No. 30909

Primary Registration District No. _____

Registered No. 8823(NO. 2642 Market Pl. ST. 17 Ward)

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

FULL NAME Albert Mathews

PERSONAL AND STATISTICAL PARTICULARS

✓ MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)maleColoredMarried

DATE OF BIRTH

Sept. 28, 1881
(Month) (Day) (Year)

AGE

33 yrs. 11 mos. 25 ds.IF LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

La.

PARENTS

NAME OF FATHER

Washington Mathews

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

La.

MAIDEN NAME OF MOTHER

Rose Gray

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

La.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cornelia Mathews(ADDRESS) 2642 Market Pl.Filed SEP 24 1914Max C. Starbuck

REGISTRAR

DATE OF DEATH

Sept 22nd, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Sept 17th, 1914, to Sept 22nd, 1914,that I last saw him alive on Sept 21st, 1914,and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis131117 (Duration) 1 yrs. 5 mos. 5 ds.

Contributory

(SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. Ambrose Smith M. D.Sept. 24th 1914 (Address) 904 N. 22nd St.

*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

Crematorium, St. Louis

DATE OF BURIAL

9/25, 1914

UNDERTAKER

J. H. Williams 3232 Corn. St.

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, 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, 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: *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.)

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.

PLACE OF DEATH

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 _____

Registration District No. 191

File No. _____

Primary Registration District No. 1003 Registered No. 8823

FULL NAME Albert Mathews

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED M
(Write the word)

DATE OF DEATH Sept 22, 1914
(Month) (Day) (Year)

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

HEREBY CERTIFY that I attended deceased from _____, 191____, to _____, 191____,
that I saw him alive on _____, 191____,
and that death occurred on the date stated above, at _____ m.

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

CAUSE OF DEATH* was as follows: Acute Gastroenteritis

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

Contributory Chronic Gastritis
Supplied (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

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) _____

(Signed) Dr. W. M. Smith
9/12/14, 1914 (Address) 904 1/2 22nd St.

*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) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) _____

Where was disease contracted if not at place of death? _____
Former or usual residence _____

Filed 12-17 1914 4.9.4. Omd
REGISTRAR

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

UNDERTAKER _____ ADDRESS _____
Supplied

Supplementary Information Supplied.

Supplementary Information Supplied.

Supplementary Information Supplied.

Supplementary Information Supplied.

Revised United States Standard Certificate of Death

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

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