

PLACE OF DEATH

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

County _____

Township _____

or
Village _____or
City St. Louis.Registration District No. 791Primary Registration District No. 1003File No. 37387Registered No. 10681(NO. Lutheran Hospital St. 16 Ward)(If death occurred in a
hospital or institution,
give its NAME instead
of street and number)FULL NAME Elsie Baerman

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)DATE OF DEATH Nov. 26, 1914
(Month) (Day) (Year)DATE OF BIRTH Mar. 12, 1888
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from
July 31, 1914, to Nov. 26, 1914,
that I last saw her alive on Nov. 25, 1914,AGE 26 yrs. 8 mos. 14 ds. IF LESS than
1 day, ___ hrs. or ___ min.?and that death occurred, on the date stated above, at 4:40 Am.OCCUPATION
(a) Trade, profession, or particular kind of work Home mfr.
(b) General nature of industry, business, or establishment in which employed (or employer) St. of at homeThe CAUSE OF DEATH* was as follows:
13 Aortic + Mitral Insuffici-
92 Aency of HeartBIRTHPLACE
(City or town, State or foreign country) St. Louis(Duration) 10 mos. ds.NAME OF FATHER Charles F. LadiburgerContributory chronic interstitial
(SECONDARY) about 20 yrs. prephritis
(Duration) (Address) 3353 NebraskaBIRTHPLACE OF FATHER (City or town, State or foreign country) Germany(Signed) Henry O'Grady M. D.
Nov. 27, 1914MAIDEN NAME OF MOTHER Bertha Wainier*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. 14 ds. In the State ___ yrs. ___ mos. ___ ds.(Informant) Ernest J. BaermanWhere was disease contracted if not at place of death? 3844 5mos.(ADDRESS) 3844 5mos. onFormer or usual residence. 3844 5mos.Filed NOV 27 1914 Marb StarkloffPLACE OF BURIAL OR REMOVAL St. Matthews cemetery DATE OF BURIAL Nov 27th, 1914UNDERTAKER Hoffmann N. Co. ADDRESS 3815 S. Belway

REGISTRAR

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) *Colton 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 synonymy 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 organ); "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.)

MISSOURI STATE BOARD OF HEALTH

(Region) _____
 (Age) _____
 (Sex) _____
 (Color) _____
 (Date of Birth) _____
 (Date of Death) _____
 (Date of Burial) _____
 (Address) _____
 (Signature) _____
 (Title) _____
 (Institution) _____
 (City) _____
 (State) _____
 (Country) _____