

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1 PLACE OF DEATH

County

Township

Village

or St Louis MO

Registration District No. 73-1008

Primary Registration District No.

(NO. 1408 N. Market Str

File No. 6495

Registered No. 1441

St. 3 Ward

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

2 FULL NAME Josephine Fechtel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH March 11th 1899
(Month) (Day) (Year)

7 AGE 25 yrs 11 mos 11 ds. If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Germany

10 NAME OF FATHER Michael Deutschman

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

12 MAIDEN NAME OF MOTHER Josephine Bobitz

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Max J. Starkloff
(Address) 1408 N. Market Str

15 Filed FEB 13 1915 Max Starkloff
Registrar

MEDICAL CERTIFICATE OF DEATH

10 DATE OF DEATH Feb 12 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 5 1915 to Feb 9 1915 that I last saw her alive on Feb 9 1915 and that death occurred, on the date stated above, at 12:55 a.m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
23A
93B
28

(Duration) 3 yrs.....mos.....ds.

CONTRIBUTORY Myocarditis
(Secondary)

(Duration) 1 yrs.....mos.....ds.

(Signed) C. M. Sullivan M. D.
2-12 1915 (Address) 2919 Sullivan

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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.....

19 PLACE OF BURIAL OR REMOVAL Calvary

DATE OF BURIAL Feb 15 1915

20 UNDERTAKER Henry Lindner ADDRESS 1417 N. Market 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, 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, 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.)

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

1 PLACE OF DEATH

County
Township
or
Village
or
City: *St. Louis* (NO. *1408 N. Market* St.: Ward)
Registration District No. *791* File No. *6495*
Primary Registration District No. *1003* Registered No. *1441*

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

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

2 FULL NAME

Josephine Fechter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *M*
(Write the word)

6 DATE OF BIRTH *mar 11 1889*
(Month) (Day) (Year)

7 AGE *25 yrs 11 mos 1 ds*
If LESS than 1 day, hrs. or min.?

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb - 12 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
.....
(Duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
..... 191..... (Address).....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address).....

15 Filed *Feb 13 1915* *max 6 Starkloff*
Register

18 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.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
..... 191.....

20 UNDERTAKER, ADDRESS

SUPPLEMENTARY

Institution Sudden

Revised United States Standard Certificate of Death

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

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