

## 1 PLACE OF DEATH

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

County .....

Township .....  
orVillage .....  
or  
City St. Louis (NO. City Hospital St. 73 Ward)Registration District No. 791  
1008

Primary Registration District No. ....

File No. 6944  
1910

Registered No. ....

2 FULL NAME Moore, Cornelius

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)  
Married

6 DATE OF BIRTH

Unknown1 833  
(Month) (Day) (Year)

7 AGE

32

yrs. mos. ds.

If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION

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

Laborer

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

9 BIRTHPLACE

(City or town, State or foreign country)

Unknown

10 NAME OF FATHER

do

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

do

12 MAIDEN NAME OF MOTHER

do

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

do

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Beulah Cornelius

(Address)

907 Lerich St

15

Filed

Feb 27 1910May C Starkloff

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 22, 1910  
(Month) (Day) (Year)

17 I 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 715 2d st.

The CAUSE OF DEATH\* was as follows:

Gunshot Wound of Chest.Homicide 1870CONTRIBUTORY Traumatic Pneumonia  
(Secondary)

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

(Signed) J P Furlong2/23, 1910 (Address) Deputy Coroner

\*State the Disease Causing Death, or, in death 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 907 Varach. St.

19 PLACE OF BURIAL OR REMOVAL

Greenwood

DATE OF BURIAL

2-27, 1910

20 UNDERTAKER

Buffin Scott

ADDRESS

2933 Pine St

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.

# 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.)

## 1 PLACE OF DEATH

County .....

Township .....

Village .....

City .....

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

Registration District No. 791

Primary Registration District No. 1003

File No. 6944

Registered No. 1910

(NO. .... St.; .... Ward)

(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number.)2 FULL NAME: Mose Cornelius

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE B 5 SINGLE  
MARRIED M  
WIDOWED  
OR DIVORCED  
(Write the word)6 DATE OF BIRTH unknown 880  
(Month) (Day) (Year)7 AGE 34 yrs. mos. 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)14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) .....  
(Address) .....15 Filed Feb 27 1915  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 22 1915  
(Month) (Day) (Year)17 I 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..... m.The CAUSE OF DEATH\* was as follows:  
.....  
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY  
(Secondary)  
(Duration)..... yrs..... mos..... ds.  
(Signed)..... M. D.  
..... 191..... (Address).....\*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 DATE OF BURIAL  
....., 191.....

20 UNDERTAKER ADDRESS

18  
2  
N E

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