

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**

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City St. Louis

Registration District No. 701

1008

File No. _____

10436

Primary Registration District No. _____

Registered No. 2289

(NO. 4017 Cook Ave. St. W Ward)

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

FULL NAME Catherine Dunwoody

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widow</u>
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DATE OF BIRTH August 24, 1866
(Month) (Day) (Year)

AGE 48 yrs. 6 mos. 13 ds.
If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE
(City or town, State or foreign country) St. Louis, Mo

PARENTS	NAME OF FATHER <u>Walter Camp</u> <i>First name unknown</i>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Germany</u>
	MAIDEN NAME OF MOTHER <u>Unknown</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Dunwoody
(ADDRESS) 4017 Cook Ave.

Filed MAR 10 1915 1915 Max Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 9, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 10th, 1915, to March 9th, 1915, that I last saw her alive on March 8th, 1915,

and that death occurred, on the date stated above, at 9³⁰ a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma
53E
8717

(Duration) 1 yrs. 1 mos. 1 ds.
Contributory Multiple Myelitis
(SECONDARY)
(Duration) 4 yrs. 6 mos. 4 ds.
(Signed) H. C. Hartman M. D.
Mar 10th, 1915 (Address) 4600 Cook Ave

*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 Bethania Cemetery DATE OF BURIAL Mar. 11, 1915

UNDERTAKER Henry Alweel ADDRESS 2002 Wash 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, 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.)

PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. 191

File No. _____

Primary Registration District No. 1003Registered No. 2289

(NO. _____)

St. _____

Ward _____

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

FULL NAME Catherine Dunwoody

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX FCOLOR OR RACE N

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

N.

DATE OF DEATH

(Month) May(Day) 9(Year) 1910

DATE OF BIRTH _____

(Month) _____

(Day) 1

(Year) _____

AGE _____

_____ yrs. _____ mos. _____ ds.

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

OCCUPATION

(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) _____

PARENTS

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) N. C. Harkins(ADDRESS) 4600 Cook Ave

Filed

MAY 7 1910Max Starkloff

REGISTRAR

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows: Carcinoma of Spinal CordContributory Multiple Neuritis

(SECONDARY)

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

(Signed) N. C. Harkins3/10 1910 (Address) 4600 Cook Ave.

*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 _____

DATE OF BURIAL _____ 191____

UNDERTAKER _____

ADDRESS _____

Original file, date _____ 19____

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

PHYSICIANS should be carefully supplied. AGE should be DEATH in plain terms, so that it may be properly classified. Exa

Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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