

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

1 PLACE OF DEATH

County

Township

Village

City

Registration District No. **791**

Primary Registration District No. **1008**

(NO. **4617 N Market** St. **26** Ward)

File No. **10822**

Registered No. **2692**

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

2 FULL NAME

Isabella Branconier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE MARRIED WIDDED OR DIVORCED (If write the word) **Married**

6 DATE OF BIRTH **June 19 1858**
(Month) (Day) (Year)

7 AGE **56 yrs. 9 mos. 1 ds.** If LESS than 1 day.....hrs. or.....min.?

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

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

10 NAME OF FATHER **John J Zimmerman**

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

12 MAIDEN NAME OF MOTHER **Malinda McLaughlin**

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) **David O Branconier**
(Address) **4617 N Market**

15 Filed **Mar 22 1915** **Mar 6 Starkloff** Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **March 20 1915**
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from **March 15th 1915**, to **March 20 1915**, that I last saw her alive on **March 20 1915** and that death occurred, on the date stated above, at **11 P. m.**

The CAUSE OF DEATH* was as follows:

93D
1108 Myocarditis
1958

(Duration)? yrs..... mos..... ds. **5**

CONTRIBUTORY (Secondary) **Pleurisy**

(Duration)..... yrs..... mos..... ds. **5**

(Signed) **C. L. Sheahan** M. D.
3/22 1915 (Address) **Blue + St. Louis**

*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 **Mar 23 1915**

20 UNDERTAKER **Cullen Kelly** ADDRESS **4526 Easton**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION.

WARRANTED, WITH UNENDING INN. THIS IS A LARGELY

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.)

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: _____ Registration District No. 791 File No. _____
 Village: _____ Primary Registration District No. 1003 Registered No. 2692
 City: Mauis (NO. 4617 N Market St. 26 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]
 FULL NAME Isabella Braucovier

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>F</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>M</u> (Write the word)	DATE OF DEATH <u>Mar 20</u> , 191 <u>9</u> (Month) (Day) (Year)
DATE OF BIRTH _____ (Month) (Day) (Year)			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 <u>11 P.</u> m.
AGE _____ IF LESS than 1 day, _____ hrs. or _____ min.			The CAUSE OF DEATH* was as follows: <u>Myocarditis</u> <u>acute dilatation of heart</u>
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed. (or employer) _____			(Duration) <u>2</u> yrs. <u>12</u> mos. _____ ds.
BIRTHPLACE (City or town, State or foreign country) _____			Contributory <u>Plumsey (not tubercular)</u> (SECONDARY) (Duration) _____ yrs. _____ mos. <u>5</u> ds.
PARENTS	NAME OF FATHER _____		(Signed) <u>E. L. Sheahan</u> M. D. <u>3/22</u> 191 <u>9</u> (Address) <u>Clark & 17th St</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
	MAIDEN-NAME OF MOTHER _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT-RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		Where was disease contracted if not at place of death? _____ Former or usual residence _____
THE [ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____			
PLACE OF BURIAL OR REMOVAL _____		DATE OF BURIAL _____ 191____	
UNDERTAKER _____		ADDRESS _____	
Filed <u>3/22</u> 191 <u>9</u> <u>5 May 6 Starkloff</u> REGISTRAR			

Original file, date _____ 19____ All information called for must be written on this Supplementary Certificate.

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Revised United States Standard Certificate of Death

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