

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

1 PLACE OF DEATH

County .....  
Township ..... Registration District No. **791** File No. **23288**  
or ..... Primary Registration District No. **1003** Registered No. **6103**  
Village .....  
or .....  
City **St. Louis Mo** (No. **1713 N. 9th Str** St. **4** Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME **Virginia Dorethea Clements**

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH **November 22 1913**  
(Month) (Day) (Year)

7 AGE **1** yrs. **7** mos. **22** ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work **None**  
(b) General nature of industry business, or establishment in which employed (or employer)

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

PARENTS  
10 NAME OF FATHER **Joseph Clements**  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) **Missouri**  
12 MAIDEN NAME OF MOTHER **Edith Landrum**  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) **Missouri**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Joseph Clements**  
(Address) **1713 N. 9th St.**

15 Filed **Nov 17 1915** **Max B. Starkloff** Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 15<sup>th</sup> 1915**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from **July 11<sup>th</sup> 1915** to **July 15<sup>th</sup> 1915** that I last saw her alive on **July 15<sup>th</sup> 1915** and that death occurred, on the date stated above, at **8:30 p.m.**

The CAUSE OF DEATH\* was as follows:

**Meningitis Cerebro**  
**24 Hours Meningitis**  
**cause not known**

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) **H. L. Church** M. D.  
**July 16<sup>th</sup> 1915** (Address) **924 Brooklyn St.**

\*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 **Friedens** DATE OF BURIAL **July 17 1915**

20 UNDERTAKER **Harry Landrum** ADDRESS **1417**

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*, *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*" ("*Con-genital*," "*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.)

N. B. - Every death certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

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

County .....  
 Township or Village St. Louis Registration District No. 791 File No. ....  
 Primary Registration District No. 1003 Registered No. 6103  
 City (NO. ....) St. .... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Virginia Dorothea Clements

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.  
 6 DATE OF BIRTH ..... 1 (Year) ..... (Month) ..... (Day) .....  
 7 AGE ..... 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) .....  
 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 July 15 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:  
Cerebro-Meningitis  
Tubercular Meningitis  
30  
 Duration yrs..... mos..... da.....  
 CONTRIBUTORY Unknown  
 (Secondary)  
 (Duration) yrs..... mos..... da.....  
 (Signed) H. L. Church  
July 16, 1915 (Address) 924 Brooklyn  
 \*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..... da..... In the State ..... yrs..... mos..... da.....  
 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, .....

Satisfactory Information Supplied.  
 SUPPLEMENTARY  
 Satisfactory Information Supplied.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) .....  
 (Address) .....  
 15 Filed Nov -2 1915 Max Starkoff Registrar

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

232800

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*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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), 29ds.; *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 septichaemia," "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.)