

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 .....

or

Village .....

or

City St Louis

Registration District No. 701

Primary Registration District No. 100B

(NO. German Hospital St. 26 Ward)

File No. 28864

Registered No. 7537

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

**2 FULL NAME** Carrie Perstrup

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female

**4 COLOR OR RACE** White

**5 SINGLE MARRIED WIDOWED OR DIVORCED** Married  
(Write the word)

**6 DATE OF BIRTH** April 12th 1882  
(Month) (Day) (Year)

**7 AGE** 33 yrs. 4 mos. 23 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) Gerald Mo

**10 NAME OF FATHER** Ulrich Scherer

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

**12 MAIDEN NAME OF MOTHER** Julia Hasse

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

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Henry Perstrup  
(Address) 5149 Ridge Ave

**15** Filed SEP -7 1915 Mar. C. Starkloff  
191 Registrar

**3 MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** Sept 4, 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:

Shock following administration of chloroform & ether.  
1915  
1915

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

(Signed) Samuel P. Gentry M. D.  
Sept 7, 1915 (Address) Government Office

\*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. 5149 Ridge Ave

**19 PLACE OF BURIAL OR REMOVAL** St Peters Cemetery

**DATE OF BURIAL** Sept 7, 1915

**20 UNDERTAKER** L. Spillman & Co.

**ADDRESS** 1321 Franklin Ave

# 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 septicæmia," "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

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

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

## CERTIFICATE OF DEATH

County .....

Township .....

or

Village .....

City .....

Registration District No. 491

File No. ....

Primary Registration District No. 1003

Registered No. 7537

(NO. ....)

St. ....

Ward) .....

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

## 2 FULL NAME Carrie Perstrup

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OF RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *M.*6 DATE OF BIRTH (Month) (Day) (Year) *1*

7 AGE If LESS than 1 day, hrs. or min. yrs. mos. ds.

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)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 Filed *Nov 10 1915* 1915*Mar 6 Starkloff*

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept. 4* 191*5*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Sept. 4 1915* to *Sept. 4 1915*, that I last saw him alive on *Sept. 4 1915*, and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH\* was as follows:

*Shock following administration of Chloroform & Ether Operation for enlarged parotid gland*  
(Duration) yrs. mos. ds. *84*

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *H. W. Fack* M. D. *9-7* 1915 (Address) *Corner Office*

\*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 .....

20 UNDERTAKER .....

ADDRESS .....

Original file, date, SEP - 1915, 19.....

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

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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.)

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