

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

1 PLACE OF DEATH

County

Township

Village

City *St. Louis*

Registration District No. *701*

File No. *16664*

Sanitary District No. *203*

Registered No. *4351*

(No. *7822* *Capin St.* St. *7* Ward)

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

2 FULL NAME *Albertine Howell*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *April 29th* 191*6*
(Month) (Day) (Year)

6 DATE OF BIRTH *March 5* 1861
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *4/28* 191*6*, to *4-29* 191*6*, that I last saw her alive on *4/29* 191*6*, and that death occurred, on the date stated above, at *8:15* p.m.

7 AGE *55* yrs. *1* mos. *24* ds.
If LESS than 1 day.....hra. or.....min.?

The CAUSE OF DEATH* was as follows:
acute obstruction of the bowels
12 1/2
(Duration) yrs. mos. *3* ds.

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

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) *D. O. W. Hill* M. D.
4-29 191*6* (Address) *153 E. Capin St.*

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

PARENTS
10 NAME OF FATHER *Fredrick Fuhr*
11 BIRTHPLACE OF FATHER *Germany*
12 MAIDEN NAME OF MOTHER *Catherine Link*
13 BIRTHPLACE OF MOTHER *Germany*

*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 *St. Monica Infirmary* of death *15* yrs. *1* mos. *15* ds. State *Mo* yrs. mos. ds.
Where was disease contracted if not at place of death? *St. Monica 15 min*
Former or usual residence *1822^a Capin St.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Geo. M. Howell*
(Address) *1822^a Capin St.*

19 PLACE OF BURIAL OR REMOVAL *Potosi, Mo.* DATE OF BURIAL *May 2* 191*6*

15 Filed *APR 29 1916* 191*6* *May 6* *Stark* Registrar

20 UNDERTAKER *W. H. Clark* ADDRESS *1485 Hodickout Ave.*

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.

Intestine obstruction

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, 8 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, 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

or

Village

or

City

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

Registration District No. 0191

File No.

Primary Registration District No. 1003Registered No. 4351

(NO.)

St.

Ward)

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME Albertine Howell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE W5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
M.

6 DATE OF BIRTH

(Month)

(Day)

1 (Year)

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
FATHER11 BIRTHPLACE
OF FATHER
(City or town, State or foreign country)12 MAIDEN NAME
OF MOTHER13 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 X

191.....

Registrar X

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) 4(Day) 129

191.....

(Year) 617 Saige J HERBY 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:

Acute obstruction of bowels
Intussusception
(Duration) yrs mos ds.
109

CONTRIBUTORY

(Secondary)

(Duration) yrs mos ds.

(Signed) H/29/1916(Address) N36 Papuska*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

Original file, date.....

APR 1916

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

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