

1 PLACE OF DEATH

County

Township

or

Village

or

City *St. Louis Mo* (No. *Gracross Hospital* 1 Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

701

19531

Registration District No.

File No.

Primary Registration District No. *1003*Registered No. *4796*2 FULL NAME *Stephen Becker*

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

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

6 DATE OF BIRTH

1859
(Month) (Day) (Year)

7 AGE

about 83
yrs. mos. ds.If LESS than
1 day..... hrs.
or..... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Manufacturer

(b) General nature of industry business, or establishment in which employed (or employer)

of Paints

9 BIRTHPLACE

(City or town, State or foreign country)

Dublin Ireland.

10 NAME OF FATHER

Thos. Becker

11 BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Plunkett

13 BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Harry J. Buster*(Address) *4329 N. 21st St.*

15

Filed *MAY 12 1916*

191

Max Starkloff

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 11
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

May 1, 191*6*, to *May 11*, 191*6*,that I last saw him alive on *May 11*, 191*6*, and that death occurred, on the date stated above, at *30* m.

The CAUSE OF DEATH* was as follows:

*Chronic interstitial nephritis**131**92A**170*

(Duration) yrs. mos. ds.

CONTRIBUTORY *Valvular Heart Disease*

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Louis H. Belmont* M. D.*May 12*, 191*6* (Address) *Dimes Building*

*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 *20* yrs. mos. ds.

Where was disease contracted if not at place of death? _____

Former or usual residence *4329 N. 21st Street*

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Calvary Cemetery *May 12*, 191*6*

20 UNDERTAKER

ADDRESS

L. Spelbrink *1321 Franklin*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHISICAL STATE and 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*, *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*, *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," "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 CERTIFICATED 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 St. Louis

Registration District No. 741 File No. 19531

Primary Registration District No. 1003 Registered No. 4796

(NO. Reconex Hospital St. 1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Stephen Becker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>	DATE OF DEATH <u>May 11, 1916</u> (Month) (Day) (Year)
DATE OF BIRTH <u>April 1, 1856</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>May 1, 1916</u> , to <u>May 11, 1916</u> , that I last saw him alive on <u>May 11, 1916</u> , and that death occurred, on the date stated above, at <u>3 P. M.</u>
AGE <u>60</u> yrs. ____ mos. ____ ds.			
OCCUPATION (a) Trade, profession, or particular kind of work <u>Bookkeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Caint</u>			The CAUSE OF DEATH* was as follows: <u>Chronic interstitial nephritis</u>
BIRTHPLACE (City or town, State or foreign country) <u>Dublin, Ireland</u>			(Duration) ____ yrs. ____ mos. ____ ds.
PARENTS	NAME OF FATHER <u>Michael Becker</u>		Contributory <u>Vascular Heart Disease</u> (SECONDARY)
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ireland</u>		(Duration) ____ yrs. ____ mos. ____ ds.
	MAIDEN NAME OF MOTHER <u>Mary Ann Dallon</u>		(Signed) <u>Louis A. Behrus</u> M. D.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ireland</u>		<u>May 12, 1916</u> (Address) <u>Times Building</u>
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harry J. Broder</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
(ADDRESS) <u>4329 N. 21st St.</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. State <u>2</u> yrs. ____ mos. ____ ds.
Filed <u>9-13</u> 191 <u>6</u> <u>Wep</u> REGISTRAR			Where was disease contracted if not at place of death? Former or usual residence <u>4329 N. 21st Street</u>
			PLACE OF BURIAL OR REMOVAL <u>Calvary Cemetery</u>
			DATE OF BURIAL <u>May 12, 1916</u>
			UNDERTAKER <u>L. Spelbrink</u>
			ADDRESS <u>4321 Franklin</u>

Original file, date _____

19

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

N. B.—Every item of information should be carefully supplied. A fee should be taken. Amount of fee should be stated. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

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

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