

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

1 PLACE OF DEATH

County .....

Township .....

Village .....

City .....

Registration District No. 701

File No. 29162

Primary Registration District No. 1003

Registered No. 7221

(NO. 1105 Armstrong Av 15 Ward)

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

2 FULL NAME

John Mundy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE

~~MARRIED~~

~~WIDOWED~~

~~OR DIVORCED~~

(Write the word)

single

6 DATE OF BIRTH

July 3 1916  
(Month) (Day) (Year)

7 AGE

30 yrs. 30 mos. 30 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) St Louis Mo.

10 NAME OF FATHER

David B. Mundy

11 BIRTHPLACE OF FATHER

Mo.

12 MAIDEN NAME OF MOTHER

Stella Kohle

13 BIRTHPLACE OF MOTHER

Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. David Mundy

(Address) 1105 Armstrong Av

15

Filed AUG 2 1916 Max G. Starkeoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 31 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

7-26-1916 to 7-31-1916

that I last saw ~~him~~ alive on 7-31-1916

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH\* was as follows:

W.A. Bronchitis

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

CONTRIBUTORY

(Secondary)

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

(Signed) W. J. Simms M. D.

8-1-1916 (Address) 6823<sup>1/2</sup> Manchester av.

\*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 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

Katawissa Mo.

DATE OF BURIAL

Aug 2, 1916

20 UNDERTAKER

E. J. Schum

ADDRESS

2652 Chateau av

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, 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.)

## 1 PLACE OF DEATH

County .....

Township  
orVillage  
or

City

REGISTRARS SHALL NOT RECEIVE  
A FEE FOR CERTIFICATES UNTIL THEY  
ARE COMPLETED AS PRESCRIBED BY  
LAWMISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Registration District No. 791

File No.

Primary Registration District No. 1003

Registered No. 7221

(No.

St.

Ward)

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

2 FULL NAME John Mundy

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

Satisfactory Information Supplied.  
(Month) (Day) (Year)

7 AGE

If LESS than  
1 day.....hrs.  
.....yrs. ....mos. ....ds.  
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  
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

AUG 10 1916  
1916  
6 Stark  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 31 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

Satisfactory Information Supplied.  
..... to ..... 191.....  
that I last saw him ..... alive of ..... 191.....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH\* was as follows:

Satisfactory Information Supplied.  
Bronchitis  
acute

(Duration) ..... yrs. 8 mos. 5 ds.

CONTRIBUTORY

(Secondary)

(Duration) ..... yrs. .... mos. .... ds.

(Signed)

8-1 1916. (Address) 6823 Manchester 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

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Original file, date

AUG 1916

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

B-Every issue of the year of the Missouri State Board of Health should state the cause of death as prescribed by the law. This is very important.

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29162