

1 PLACE OF DEATH

County

Township

or

Village

or

City *St. Louis Mo.* (NO *St. Anthony's Hosp. St.* *15* Ward)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

791

File No. 36153

1003

Registered No. 9751

2 FULL NAME *Irene Cecelia Kochler*

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*6 DATE OF BIRTH *Nov 22* 19*00*
(Month) (Day) (Year)7 AGE *15* yrs. *11* mos. *X* 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) *School Girl*9 BIRTHPLACE (City or town, State or foreign country) *St. Genevieve Mo.*10 NAME OF FATHER *Walter Kochler*11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *St. Genevieve Mo.*12 MAIDEN NAME OF MOTHER *Pauline Glaser*13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Lawsencetown Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Pauline Kochler*(Address) *2723 Russell ave.*15 Filed *Oct 23 1916* *Max C. Starkloff* Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 22 1916*
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Oct 17*, 1916, to *Oct 22*, 1916, that I last saw *her* alive on *Oct 21*, 1916, and that death occurred, on the date stated above, at *2:30 a.m.*The CAUSE OF DEATH* was as follows:
1948
210
210
78
Acute Encephalitis
(Duration) yrs. mos. *3* ds.CONTRIBUTORY *Sept. Casus inflexion*
Left (Duration) yrs. mos. ds.
(Signed) *Walter J. Blosser* M. D.
Oct 23, 1916 (Address) *1524 1/2 Jefferson*

*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. *4* ds. In the *15* yrs. *11* mos. *X* ds.Where was disease contracted *unknown* if not at place of death?Former or usual residence *2723 Russell Ave.*19 PLACE OF BURIAL OR REMOVAL *Calvary Cemetery* DATE OF BURIAL *Oct. 24, 1916*20 UNDERTAKER *Petch Bros* ADDRESS *2739 Lafayette ave**searched check with filing ev*

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*; *Broncho-pneumonia* ("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.)