

## 1 PLACE OF DEATH

County .....

Township .....

or .....

Village .....

or *St Louis Mo.*

City .....

Registration District No. *701*File No. *39138*Primary Registration District No. *1008*Registered No. *10438*(NO. *Mullamphy Hosp.* St. *4* Ward)

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

2 FULL NAME *John Theodore Wisniewsky*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Single*  
(Write the word)6 DATE OF BIRTH *Jan 15<sup>th</sup> 1893*  
(Month) (Day) (Year)7 AGE *23 yrs 10 mos 28 ds.* If LESS than 1 day.....hrs. or.....min.?8 OCCUPATION (a) Trade, profession, or particular kind of work *Shoe worker*(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 *Theodore Wisniewsky*11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *St Louis Mo.*12 MAIDEN NAME OF MOTHER *Theresia Otten*13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *St Louis Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Adelardo Wisniewsky*(Address) *822 A Tyler St.*15 Filed *11 15 1916*

Registrar

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

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *November 13<sup>th</sup> 1916*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Nov 11<sup>th</sup> 1916* to *Nov 12<sup>th</sup> 1916*, that I last saw him alive on *Nov 12<sup>th</sup> 1916*and that death occurred, on the date stated above, at *9:00 p.m.*

The CAUSE OF DEATH\* was as follows:

*12110 Appendicitis 108*  
(Duration)..... yrs..... mos. *9* ds.

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

(Signed) *Henry A. Sumner* M. D. *Nov 14<sup>th</sup> 1916* (Address) *3707 N 11<sup>th</sup>*

\*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. *3* ds. In the *Life* State..... yrs..... mos..... ds.Where was disease contracted if not at place of death? *822 A Tyler St.*Former or usual residence. *822 A Tyler St.*19 PLACE OF BURIAL OR REMOVAL *Cabary* DATE OF BURIAL *Nov 16<sup>th</sup> 1916*20 UNDERTAKER *Aug Brockland & Co.* ADDRESS *1421 N. 9<sup>th</sup>*

# 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 (not paid *Housekeepers* who receive a definite salary), entered as *Housewife*, *Housework*, or *At home*, and if not gainfully employed, as *At school* or *At home*. Do not be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Housemaid*, etc. If the occupation has been given up on account of the DISEASE CAUSING 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.)

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1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

CERTIFICATE OF DEATH

County .....

Township .....

or Village .....

or City *St. Louis* (NO. ....)

Registration District No. *791*

File No. ....

Primary Registration District No. *1003*

Registered No. *10438*

St. .... Ward

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

2 FULL NAME

*John Theodore Wisniewsky*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *S*

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE yrs. mos. ds. If LESS than 1 day hrs. 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)

PARENTS 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 1917* *Max G Starkloff* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) *Nov 13 1916*

17 I HEREBY 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 The CAUSE OF DEATH\* was as follows:

(Duration) yrs. mos. ds. CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. 191 (Address)

\*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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH

JURISDICTIONAL TERRITORY SUPPLIED

# Revised United States Standard Certificate of Death

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

39138

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