

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

1 PLACE OF DEATH
County St Charles
Township St Charles or
Village St Charles or
City St Charles (NO. 609 Houston St. 3 Ward) Registration District No. 757 File No. 26276 Primary Registration District No. 3036 Registered No. 99

2 FULL NAME Jennie Baird

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

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE <u>Married</u> MARRIED WIDOWED OR DIVORCED (Write the word)	16 DATE OF DEATH <u>July 7</u> 191 <u>7</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>July 2</u> 18 <u>64</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY, that I attended deceased from <u>May 16</u> 191 <u>5</u> to <u>July 7</u> 191 <u>7</u> that I last saw <u>her</u> alive on <u>July 6</u> 191 <u>7</u> and that death occurred, on the date stated above, at <u>7:30 a.m.</u>	
7 AGE <u>53</u> yrs. <u>—</u> mos. <u>5</u> ds.		If LESS than 1 day, ... hrs. or min.?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business or establishment in which employed (or employer) <u>St Charles Co Mo</u>			
9 BIRTHPLACE (City or town, State or foreign country) <u>St Charles Co Mo</u>			
PARENTS	10 NAME OF FATHER <u>James R Dougherty</u>		
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>		
	12 MAIDEN NAME OF MOTHER <u>Barrie B. Cornfelter</u>		
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>London</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. J. Baird</u> (Address) <u>St Charles Mo</u>			
15 Filed <u>July 9</u> 191 <u>7</u> at <u>Houston</u> Registrar			
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 <u>Valhalla Cemetery</u> 20 UNDERTAKER <u>Steinbrinker Funeral</u>	
DATE OF BURIAL <u>July 9</u> 191 <u>7</u>		ADDRESS <u>St Charles Mo</u>	

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, peritoneum*, 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.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

St. Charles

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

Township

or

Village

or

City

St. Charles

Registration District No.

757

File No.

Primary Registration District No.

3036

Registered No.

99

NO. 609 Houston

St.

Ward)

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

2 FULL NAME

Jennie Baird

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

July 2, 1864

7 AGE

53 yrs. - 3 mos. - 3 ds.

If LESS than
1 day, hrs.
or min.?

8 OCCUPATION

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

At home

(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
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

Sept 7th 1917

John A. Weinstein
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 7, 1917

17

I HEREBY CERTIFY, that I attended deceased from

191 to 191

that I last saw h. alive on 191

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

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept 6, 1917 (Address) St. Charles MO

*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 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, 19

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

Revised United States Standard Certificate of Death

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

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