

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

1 PLACE OF DEATH

36463

9795

County

Township
or
Village
or
City *Louis Mo* (NO *Alexia Bro* St. *11* Ward)

Registration District No. *725* File No.

Primary Registration District No. *1003* Registered No.

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

2 FULL NAME *Wm J Prendergast*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH *October 7th 1917*
(Month) (Day) (Year)

6 DATE OF BIRTH *Dec 0 1891*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *September 15, 1917*, to *October 7th, 1917*, that I last saw him alive on *October 7th, 1917*, and that death occurred, on the date stated above, at *5:30 P.M.*

7 AGE *25* yrs. *9* mos. *1* ds. If LESS than 1 day, hrs. or min.?

The CAUSE OF DEATH* was as follows:

8 OCCUPATION (a) Trade, profession, or particular kind of work *Gen. Machinist* (b) General nature of industry, business, or establishment in which employed (or employer) *Wm. S. Sells*

Bronchial Pneumonia
11/7/17
34

9 BIRTHPLACE (City or town, State or foreign country) *Desoto Mo*

(Duration) yrs. mos. ds.

10 NAME OF FATHER *Edward Prendergast*

CONTRIBUTORY *Henientia Precox* (Secondary) (Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Louis Mo*

(Signed) *E. G. Kelly* M. D. *Oct 8th 1917* (Address) *Alexia Bro. Hosp.*

12 MAIDEN NAME OF MOTHER *Budget Beem*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ireland*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Edw. Prendergast* (Address) *Desoto Mo*

Where was disease contracted if not at place of death? Former or usual residence *Desoto Mo*

15 Filed *Oct - 8 1917* *Max C. Harkloff* Registrar

19 PLACE OF BURIAL OR REMOVAL *Desoto Mo* DATE OF BURIAL *10/8/17*

20 UNDERTAKER *M. H. Alexander* ADDRESS *2835 Olive*

Information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should state 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), *20 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

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

County

Township

Village

City

Registration District No. 791

File No.

Primary Registration District No. 1003

Registered No. 9795

(NO. *Alexian Bros* St. 11 Ward)

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

2 FULL NAME

Wm f Prendergast

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

16 DATE OF DEATH

Oct. 7, 191*7*
(Month) (Day) (Year)

6 DATE OF BIRTH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

7 AGE

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

that I last saw him alive on 191.....
and that death occurred, on the date stated above, at m.

8 OCCUPATION

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

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

The CAUSE OF DEATH* was as follows:

9 BIRTHPLACE

(City or town,
State or foreign country)

(Duration) yrs. mos. ds.

10 NAME OF FATHER

Will P Prendergast

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

11 BIRTHPLACE
OF FATHER
(City or town, State or foreign country)

St Louis Mo

(Signed) *D G Piley* M. D.

12 MAIDEN NAME
OF MOTHER

Edna Ball

191..... (Address) *3973 S Broadway*

13 BIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

De Soto Mo

*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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Will P Prendergast

Box 534
(Address) *De Soto Mo.*

15

Filed *NOV 24 1917* *Max B. Starckoff*
Registrar

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191.....

20 UNDERTAKER

ADDRESS

properly classified. Exact date

SUPPLEMENTARY Satisfactory Information Supplying

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: *Farmér (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);

36463
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), 29ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthénia," "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 septichaemia," "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

or

Village

or

City *Morris* (NO.) St. Ward)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 DEATHRegistration District No. *791*

File No.

Primary Registration District No. *1003*Registered No. *9795*2 FULL NAME *Wm. J. Prudergast*[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]

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 *Dec x 11th 1891*
(Month) (Day) (Year)7 AGE If LESS than
1 day... hrs.
or... min.?
yrs. mos. ds.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 *DEC 29 1917**Mark Starloff*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 7 1917*
(Month) (Day) (Year)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:

CONTRIBUTORY
(Secondary)*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 residences

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

..... 191.....

20 UNDERTAKER

ADDRESS

Alvan

Original file, date....., 19.....

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

N. B.—Every item of information shown here should be carefully supplied, if not at the time of death, it should be supplied as soon as possible. Every item of information should be given, so that the cause of death may be ascertained.

SUPPLEMENTARY CERTIFICATE

Revised United States Standard Certificate of Death

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

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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), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthemia," "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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