

1 PLACE OF DEATH

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

County

Township

Village

City

Registration District No. 791

File No. 36519

Secondary Registration District No. 1003

Registered No. 9854

(NO. *Missouri Bell San 75* Ward)

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

2 FULL NAME *Stella Viola Johnston*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Wid.*
(Write the word)6 DATE OF BIRTH *Dec 10* 1877
(Month) (Day) (Year)7 AGE *39* yrs. *9* mos. *29* ds. If LESS than 1 day.....hrs. or.....min.?8 OCCUPATION
(a) Trade, profession, or particular kind of work *House wife*
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE
(City or town, State or foreign country) *Mo.*10 NAME OF FATHER *John J. Johnston*11 BIRTHPLACE OF FATHER
(City or town, State or foreign country) *Mo.*12 MAIDEN NAME OF MOTHER *Susana Silstrup*13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country) *Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Dr. W. Allen*(Address) *Callao, Mo.*15 Filed *Oct 10 1917* *Marb Starrhoff* Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 9* 1917
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *10 AM Oct 9, 1917* to *4 PM Oct 9, 1917*
that I last saw him alive on *Oct 9, 1917*
and that death occurred, on the date stated above, at *4 PM*.

The CAUSE OF DEATH* was as follows:

Goiter (opthalmic)
10/15
29 (15)
1
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY *Heart disease*
(Secondary)

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

(Signed) *Rev. L. Porter* M. D.
W. Allen M. D.
Callao, Mo.
(Address) *Callao, Mo.*

*State the Disease Causing Death, or, in death from Violent Cause, the (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 *Callao Mo*
if not at place of death?Former or usual residence *Callao Mo*19 PLACE OF BURIAL OR REMOVAL *Callao, Mo* DATE OF BURIAL *Oct 11, 1917*20 UNDERTAKER *Craig Williams* ADDRESS *1238 1/2 Kingshighway*

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 child-birth 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.)

1916
39
1777

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. A GP should be stated if not a V. PHYSICIANS should state their specialty. A CAUSE OF DEATH in plain terms, so that it may be properly understood.

1 PLACE OF DEATH

County
Township
or
Village
or
City *St. Louis* (NO.) (St.) (Ward)

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

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

Registration District No. *791* File No.
Primary Registration District No. *1003* Registered No. *9854*

2 FULL NAME *Stella Viola Johnston*

(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 *F* 4 COLOR OR RACE *W* 5 SINGLE MARRIED OR DIVORCED (Write the word) *W*

16 DATE OF DEATH 191...
(Month) (Day) (Year)

6 DATE OF BIRTH 191...
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191... to 191...
the first saw him alive on 191...
and that death occurred, on the date stated above, at m.

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

18 CAUSE OF DEATH* was as follows:

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

Spiles (Apholmie)
Chronic Myocarditis
(Duration) yrs. mos. ds.

9 BIRTHPLACE (City or town, State or foreign country)

CONTRIBUTORY (Secondary) *Heart dis.*
(Duration) yrs. mos. ds.

10 NAME OF FATHER

(Signed) M. D.

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

191... (Address)

12 MAIDEN NAME OF MOTHER

*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)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
Information secured in the
of death yrs. mos. ds. State yrs. mos. ds.
Others were disease contracted from Dr. B. L. Doney,
if not at place of death?
Metropolitan Bldg.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
(Address)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191...

15 Filed *DEC 19 1911* *Mar E Startloff*
Registrar

20 UNDERTAKER ADDRESS

Revised United States Standard Certificate of Death

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

61592
36519

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