

## 1 PLACE OF DEATH

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

County .....

Township .....

Village .....

City *St. Louis* (No. *4057 Lucky*) St. *M* Ward)Registration District No. *791*File No. *39463*Primary Registration District No. *1003*Registered No. *10667*2 FULL NAME *Martin Griffin*

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OF DIVORCED *Single*  
(Write the word)6 DATE OF BIRTH *Don't know*  
(Month) (Day) (Year)7 AGE *abt 53* yrs. mos. ds. If LESS than 1 day...hrs. or...min.?8 OCCUPATION (a) Trade, profession, or particular kind of work *Laborer Day*  
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE (City or town, State or foreign country) *ms*PARENTS 10 NAME OF FATHER *Thomas Griffin*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ireland*  
12 MAIDEN NAME OF MOTHER *Mary Dowd*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ireland*14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *Thos Griffin*  
(Address) *4057 Lucky*15 Filed *Nov 7 1917* *Max C Starkoff*  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 5 1917*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *Nov 5 1917*  
to *Nov 5 1917*that I last saw him alive on *Nov 3 1917*  
and that death occurred, on the date stated above, at *7:45* m.The CAUSE OF DEATH\* was as follows:  
*Hemorrhage of being Rupture Acquisition of Aorta*  
(Duration) yrs. mos. ds. *W. M. A*CONTRIBUTORY (Secondary) *W. M. A*  
(Duration) yrs. mos. ds.(Signed) *Rudolph S. Pitt* M. D.  
*Nov 7 1917* (Address) *Coronet*

\*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 *4059 Page Ave*19 PLACE OF BURIAL OR REMOVAL *Calvary Cem* DATE OF BURIAL *Nov 7 1917*20 UNDERTAKER *M Farland, Jun* ADDRESS *4038 East*

# 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), 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.)

1 PLACE OF DEATH

County .....  
 Township .....  
 or  
 Village .....  
 or  
 City *St. Louis*

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

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

Registration District No. *791* File No. ....  
 Primary Registration District No. *1003* Registered No. *10667*  
 (NO. *457 Lucky* St. *32* Ward)

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

2 FULL NAME *Martha Giffin*

PERSONAL AND STATISTICAL PARTICULARS

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

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

MEDICAL CERTIFICATE OF DEATH

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

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 ..... m.

The CAUSE OF DEATH\* was as follows:  
*Fracture of tibia*  
*rupture and shock of vessel of*  
*artery of the leg*  
*98 yrs*  
 (Duration) yrs. mos. ds.

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

(Signed) *Not Path* M. D.  
*12/20, 1917* (Address) *Deputy Comm*

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 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.....

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) .....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL ..... 191.....  
 20 UNDERTAKER ADDRESS.....

15  
*Filed 12/20/17*  
*Mar E. Starckoff*  
 Registrar

SUPPLEMENTARY INFORMATION SUPPLIED

# Revised United States Standard Certificate of Death

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Association]

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*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 "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.)*