

PHYSICIANS should state exact statement of OCCUPATION is very important.

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

6328

1 PLACE OF DEATH

County St. Louis,
 Township Carondelet,
 or
 Village Post Hospital,
 or
 City Jefferson Barracks, Mo (NO. _____ St.: _____ Ward)

Registration District No. 1123 File No. _____
 Primary Registration District No. 6248B Registered No. 110

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

2 FULL NAME Roscoe E. Smith,

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---|--|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u> |
| 6 DATE OF BIRTH <u>Unknown</u> , 18 <u>97</u> (Month) (Day) (Year) | | |
| 7 AGE <u>20</u> yrs. _____ mos. _____ ds. | | If LESS than 1 day, _____ hrs. or _____ min.? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Soldier</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>Soldier</u> | | |
| 9 BIRTHPLACE (City or town, State or foreign country) <u>North Dakota</u> | | |
| PARENTS | 10 NAME OF FATHER | <input checked="" type="checkbox"/> |
| | 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) | <input checked="" type="checkbox"/> |
| | 12 MAIDEN NAME OF MOTHER | <input checked="" type="checkbox"/> |
| | 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) | <input checked="" type="checkbox"/> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. E. Wynn
Major, M.R.C., U. S. Army
 (Address) Jefferson Barracks, Mo.

15 FEB 11 1918
 Filed _____ 1918 L. C. Obrock
 Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
February 8, 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
Jan. 4, 1918, 1918, to Feb'y 8, 1918,
 that I last saw him alive on Feb'y 8, 1918,
 and that death occurred, on the date stated above, at 3:30 A. m.
 The CAUSE OF DEATH* was as follows:
Scarlet fever following empyema, acute,
right side secondary to pneumonia (lobar)
lower lobe, right lung.
 (Duration) 19 yrs. 9 mos. _____ ds.
 CONTRIBUTORY (Secondary) NO
 (Duration) 8 yrs. _____ mos. _____ ds.
 (Signed) W. E. Wynn
Major, M.R.C., U. S. Army M. D.
Feb. 8, 1918 (Address) Jefferson Barracks.

*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 La Toure P. C. DATE OF BURIAL FEB 11 1918
 20 UNDERTAKER Southern ADDRESS 73135 Bldg

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 "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "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.)

REGISTRATION IS VERY IMPORTANT.

PLACE OF DEATH

County Haus
Township Cambell
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 1123 File No. _____
Primary Registration District No. 6248 Registered No. 110

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

FULL NAME

Rose E. Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OF RACE W SINGLE A MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

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

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

PARENTS NAME OF FATHER Not Known BIRTHPLACE OF FATHER Not Known MAIDEN NAME OF MOTHER Not Known BIRTHPLACE OF MOTHER Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

(ADDRESS) _____

APR 22 1918 L. C. Brock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 7 8, 1918 (Month) (Day) (Year)

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: _____ (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.

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 _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

6328

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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 septicæmia," "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.)