

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

11225

County

Township

or

Village

or

City *St Louis*

Registration District No.

791

File No.

Primary Registration District No.

1003

Registered No.

3023

(NO) *Barnes Hopt* St. *75* Ward

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

2 FULL NAME *Linckrey Brewer*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLES

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Jan 18

(Month)

(Day)

1

1861

(Year)

7 AGE

57

yrs.

2

mos.

2

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)

Farmer

9 BIRTHPLACE

(City or town, State or foreign country)

Virginia

10 NAME OF FATHER

Wm Brewer

11 BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Virginia

12 MAIDEN NAME OF MOTHER

Susan Bell

13 BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs J. A. Thomas*(Address) *4034 California*

15

MAR 20 1918

Filed

Mar B Starks off

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 20

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Mar 3 1918, to *Mar 20* 1918,that I last saw him alive on *Mar 20* 1918,and that death occurred, on the date stated above, at *5:45 am*.

The CAUSE OF DEATH* was as follows:

*Epididymitis, Tuberculosis of operation**20* (Duration) yrs. mos. ds.36 CONTRIBUTORY *Septicaemia*

(Duration) yrs. mos. ds.

(Signed) *L. R. Rose* M. D.*3-20* 1918 (Address) *Barnes H.*

*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) *Barnes Hopt*

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? *Cuba No*Former or usual residence *Cuba No*

19 PLACE OF BURIAL OR REMOVAL

Cuba No

DATE OF BURIAL

Mar 21 1918

20 UNDERTAKER

Aug Brn Hopt

ADDRESS

2739 Lafayette

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.)

Please ask the Phys
to state Cause and
reason for which the
Operation was performed
~~Dr Rose is in the Army and~~
the information secured was from the
hospital record. L. Groves
Dir of V. S.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

The enclosed certificate is defective for the reason that
the cause of death is not stated.

Please correct, sign and return, together with this card.

J. A. B. ADCOCK, M. D.,

State Registrar.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 3023(NO. Barns-Hasp)

St. _____

Ward _____

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

FULL NAME Linckey Burns

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE M
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) _____

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 20, 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:

Septicidymitis - tubercular
operation
Septicidymitis

(Duration) _____

yrs.

mos.

Contributory Septicidymitis

(SECONDARY)

(Duration) _____

yrs.

mos.

(Signed) _____

191____

(Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____

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

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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117225
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.)