

## 1 PLACE OF DEATH

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

County .....

Township .....

or .....

Village .....

or .....

City *St. Louis* (NO. *2905 Morgan* St. *19* Ward)Registration District No. *791*File No. *11421*Primary Registration District No. *1003*Registered No. *3232*

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

2 FULL NAME *Anna Anderson*

## PERSONAL AND STATISTICAL PARTICULARS

## 2 MEDICAL CERTIFICATE OF DEATH

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Widower*  
(Write the word)16 DATE OF DEATH *March 27 1918*  
(Month) (Day) (Year)6 DATE OF BIRTH *Unknown* *859*  
(Month) (Day) (Year)17 I HEREBY CERTIFY that I attended or passed from *March 20 1918 to March 27 1918*  
1918 to 19187 AGE *37* yrs. mos. ds. IF LESS than 1 day hrs. or min.?that I last saw him alive on *March 22 1918*  
and that death occurred, on the date stated above at *9 a.m.*8 OCCUPATION (a) Trade, profession, or particular kind of work *Housewife*  
(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) *Tennessee**Angina Pectoris*10 NAME OF FATHER *Unknown**947 90*11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Unknown**113 80*  
(Duration) yrs. mos. ds.  
*Sa*12 MAIDEN NAME OF MOTHER *Winnie Kennedy*CONTRIBUTORY (Secondary) *W. W. Moore*  
(Signed) *W. W. Moore* M.D.13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Tennessee*(Duration) yrs. mos. ds.  
*3-27-18* (Address) *1376 E*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) *Ada Mason*18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
At place of death yrs. mos. ds. In the State yrs. mos. ds.(Address) *316 Lincol*

Where was disease contracted if not at place of death? .....

Former or usual residence .....

15 *MAR 26 1918* *Mar C. Stackliff*  
Filed 1918 Registrar19 PLACE OF BURIAL OR REMOVAL *Greenwood* DATE OF BURIAL *March 27 1918*20 UNDERTAKER *W. C. Gordon* ADDRESS *2649 Morgan St*

# 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

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

County .....  
 Township ..... or Village ..... or City *St. Louis* .....  
 Registration District No. *791* File No. ....  
 Primary Registration District No. *1003* Registered No. *3932*  
 NO. *2905 Morgan* St. *19* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*X Annie Alexander X*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Widower*  
(Write the word)

6 DATE OF BIRTH *Unknown 1870*  
(Month) (Day) (Year)

7 AGE *48* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS  
 10 NAME OF FATHER *Unknown*  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Unknown*  
 12 MAIDEN NAME OF MOTHER *Mamie Kennedy*  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Term*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) *Ada Mason*  
 (Address) *3076 Simple*

15 APR 22 1918  
 Filed *Max C. Starosoff* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 24 1918*  
(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:

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

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds.  
 (Signed) ..... M. D.  
 ..... 191..... (Address) .....

\*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 *Greenwood* DATE OF BURIAL *Mar 28 1918*

20 UNDERTAKER *W. C. Gordon* ADDRESS *3649 Morgan*

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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

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119111  
*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 "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.)