

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

1 PLACE OF DEATH

County

Township

or

Village

or

City *St. Louis Mo.* (No. *2908 Park Ave.*) St. *15* Ward

Registration District No. *791*

File No. *11666*

Primary Registration District No. *1003*

Registered No. *3491*

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

2 FULL NAME *Magretha K. Stumborg*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OF DIVORCED *Widowed*
(Write the word)

16 DATE OF DEATH *March 31, 1918*
(Month) (Day) (Year)

6 DATE OF BIRTH *12 2 1832*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Oct 16th, 1916*, to *Mar 31, 1918*, that I last saw her alive on *Mar 31, 1918*, and that death occurred, on the date stated above, at *5:55 a.m.*

7 AGE *85 3 28*
..... yrs. mos. ds. If LESS than 1 day..... hrs. or..... min.?

The CAUSE OF DEATH* was as follows:
Fibros-cystoma of left ovary.
54A (Duration) *4* yrs. mos. ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *Thos J. Burt* M. D. *4/1/18*, 191..... (Address) *4743 Lohrie*

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

10 NAME OF FATHER *Could not be ascertained*

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

12 MAIDEN NAME OF MOTHER *Could not be ascertained*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Germany*

*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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Thos Stumborg*

19 PLACE OF BURIAL OR REMOVAL *Bellefontaine* DATE OF BURIAL *4/2, 1918*

(Address) *2908 Park Ave*

20 UNDERTAKER *Harry Neier 3433* ADDRESS *St. Louis Mo*

Filed *APR - 2 1918*, 191.....

Registrar *Marlo Starckoff*

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 *Nona*.

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 *Staus*

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. *791* File No.
 Primary Registration District No. *1003* Registered No. *3494*
 (NO. *2908 Park an* St. *15* Ward)

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

2 FULL NAME

Magntha. K. Steimborg

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE
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)

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)

15 Filed *JUN 10 1918* *Max C. Starloff*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 31 1918*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191..... to 191.....
 that I last saw him/her alive on information supplied, 191.....
 and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Fibros - Cystoscopy of left
Artery.
 (Duration) yrs. mos. ds.

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

*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)
Place causal unknown!
 (Duration) yrs. mos. ds. In the State of
 Where was disease contracted if not at place of death?
over phone from Dr. J.H. Becker
 Former or usual residence
 DATE OF BURIAL *5-16-18*

19 PLACE OF BURIAL OR REMOVAL *Brookview*
 DATE OF BURIAL *5-16-18*
 191.....

20 UNDERTAKER ADDRESS

SUPPLEMENTARY
 INFORMATION SUPPLIED
 BY DISTRICT REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health 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 inter-current) 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.)