

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

.1 PLACE OF DEATH

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

Registration District No. 701

File No. 31129

Primary Registration District No. 1008

Registered No. 9048

(NO. Children Hospital St. N Ward)

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

2 FULL NAME Gunnar O. Pearson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH Dec 3 1906
(Month) (Day) (Year)
7 AGE 11 yrs. 9 mos. 28 ds.
If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION Schoolboy 22
Trade, profession, or regular kind of work
9 GENERAL NATURE OF INDUSTRY, BUSINESS, OR ESTABLISHMENT IN WHICH EMPLOYED (OR EMPLOYER) 186 104

BIRTHPLACE (City or town, State or foreign country) St. Louis

10 NAME OF FATHER Carl A. Pearson

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

12 MAIDEN NAME OF MOTHER Caroline Luecke

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth Bartlett
(Address) 500 S. Kingshighway

15 Filed DEC - 2 1913 Max B. Startloff
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 29 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 29 1918 to Sept 29 1918, that I last saw him alive on Sept 29 1918 and that death occurred, on the date stated above, at 1:29 p.m.
The CAUSE OF DEATH* was as follows:

Petanus
Following compound fracture of Left Arm
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Accident
(Duration).....yrs.....mos.....ds.

(Signed) Russell S. Ditt, M. D.
Sept 29 1918 (Address) Coroner

*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 11 yrs. 9 mos. 28 ds.
Where was disease contracted if not at place of death? 6522 Odell ave
Former or usual residence. 6522 Odell ave

19 PLACE OF BURIAL OR REMOVAL St. Peters **DATE OF BURIAL** Oct 1 1918

20 UNDERTAKER Blenheim **ADDRESS** 3163 S. ...

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

St. Ward

If death occur
hospitals or institutions,
give his NAME
of street and num

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

..... (Month) 1 (Day) 1 (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)

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

....., 191

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) 19th (Day) 191

17 I HEREBY CERTIFY, that I attended deceased

that I last saw h..... alive on.....

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos.

(Signed)

....., 191..... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal, or Recent Residents (For Hospitals, Institutions, Transients or 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.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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

1. PLACE OF DEATH

County St. Louis Registration District No. 791 File No. 9048
 Township St. Louis Primary Registration District No. 1003 Registered No. 9048
 City St. Louis (No. St. Ward)

FULL NAME

Guyon, O. Benson
 (a) Residence, No. Ward. (If nonresident give city or town and State)
Childers Hosp. 24

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

11. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

INFORMANT (Address)

15. Mar. 6 Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1918

17. I HEREBY CERTIFY, That I attended deceased from , 1918, to , 1918, that I last saw alive on , 1918, and that death occurred on the date stated above, at St. Louis, Mo.

THE CAUSE OF DEATH WAS AS FOLLOWS:

St. Louis
falling compound
fracture of left arm.
 (duration) yrs. mos. ds. accident

CONTRIBUTORY (SECONDARY)

Falling in yard while at
 (duration) yrs. mos. ds. 1777 year

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) R. S. Pitt, M. D.
 , 1918 (Address) Coronet

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

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) *Colton 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*; *Broncho-pneumonia* ("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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

31129