

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*  
Primary Registration District No. *1008*  
(NO *1945 Arsenal*)

File No. *36249*  
Registered No. *3620*  
St. *15* Ward

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

2 FULL NAME *Fred W Buseckus*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *Sept 4 1872*  
(Month) (Day) (Year)

7 AGE *46 yrs 1 mos 10 ds.* If LESS than 1 day.....hrs. or.....min.?

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

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

PARENTS  
10 NAME OF FATHER *Fred Buseckus*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Germany*  
12 MAIDEN NAME OF MOTHER *Laura Wells*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ill*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Marie Buseckus*  
(Address) *1945 Arsenal St.*

15 Filed *OCT 16 1918* *Marie Starckoff* Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 14 1918*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *10/12/18*, 191*8*, to *10/14*, 191*8*, that I last saw him alive on *10/13*, 191*8*, and that death occurred, on the date stated above, at *9:30 a. m.*

The CAUSE OF DEATH\* was as follows:  
*Influenza*  
*IIA*  
*1079* *10*  
(Duration).....yrs.....mos. *6* ds.

CONTRIBUTORY *Pneumonia*  
(Secondary) (Duration).....yrs.....mos. *3* ds.  
(Signed) *W. H. Thies* M. D.  
*10/15*, 191*8* (Address) *1536 Poplar St*

\*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 *New Chester* DATE OF BURIAL *Oct 11, 1918*

20 UNDERTAKER *J. S. Mussoletto & Sons* ADDRESS *1407 Marich 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) *Sales-grocery*; (a) *Foreman*, (b) *Automobile factory*.  
Never return "Laborer," "Foreman," "Dealer," etc., without more precise on, as *Day laborer*, *Farm laborer*, *Laborer*—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 child-birth 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.)

**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. 9620  
 Township St. Louis Primary Registration District No. 1003 Registered No. 9620  
 City St. Louis (No. 1945, Annual) St.            Ward           

**2. FULL NAME**

(a) Residence. No.            St.            Ward             
 (Usual place of abode) (If nonresident give city or town and State)  
 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 OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (Use the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF           

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

7. AGE YEARS MONTHS DAYS H LESS than 1 day, hr. 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           

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

12. MAIDEN NAME OF MOTHER           

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

14. INFORMANT (Address)           

15. FILED 19 May 6 Starkloff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1918

17. I HEREBY CERTIFY, That I attended deceased from           , 19           , to           , 19           , that I last saw b.            alive on           , 19           , and that death occurred, on the date stated above, at            m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: 10  
Pneumonia (duration)            yrs.            mos.            ds.  
 CONTRIBUTORY (SECONDARY)            (duration)            yrs.            mos.            ds.

18. WHERE WAS DISEASE CONTRACTED            information secured from            from            IF NOT AT PLACE OF DEATH.  
 DID AN OPERATION PRECEDE DEATH?            DATE OF           

WAS THERE AN AUTOPSY?             
 WHAT TEST CONFIRMED DIAGNOSIS?             
 (Signed)            M. D.  
2-11-19 (Address)

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

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

20. UNDERTAKER            ADDRESS           

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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

36249

"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," "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.)

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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.