

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

43628

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1008
 City St. Louis (No. 2615 Pine)..... St. 17 Ward.....
 (If nonresident give city or town and State)

2. FULL NAME

J. Jackson
 (a) Residence No. 2615 Pine St. 17 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 Male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown/1878

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>abt. 40</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Not Ascertainable

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 H.W. Fath
 (Address) Co. office

15. FILED may 6 Stanloff 19 1918
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 25th 1918

17. I HEREBY CERTIFY, That I attended deceased from.....
Found dead 19....., 19.....
 that I last saw alive on....., and that
 death occurred, on the date stated above, at 3-45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Endocarditis
W.M.A.
 (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) Pulmonary Congestion
 (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? H.W. Fath
 (Signed).....
3/6, 19 18 (Address) Deputy Comm.

*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 Butter Field DATE OF BURIAL 12/7/1918

20. UNDERTAKER Hates-Mannell ADDRESS 4107 Hanney

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 class of various pursuits can be known. The applies to each and every person, irrespec- For many occupations a single word or first line will be sufficient, e. g., *Farmer* or *Physician*, *Composer*, *Architect*, *Locomotor*, *Civil engineer*, *Stationary fireman*, etc. In many cases, especially in industrial employ- necessary to know (a) the kind of work (b) the nature of the business or industry, (c) an additional line is provided for the statement; it should be used only when needed. Examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleswoman*, (b) *Department store*; (a) *Foreman*, (b) *Automobile factory*. Material worked on may form part of the statement. Never return "Laborer," "Foreman," "Dealer," etc., without more specification, as *Day laborer*, *Farm laborer*, *Coal mine*, etc. Women at home, who are confined to the duties of the household only (not paid for services who receive a definite salary), may be classified as *Housewife*, *Housework* or *At home*, and if gainfully employed, as *At school* or *At work*. There should be taken to report specifically occupations of persons engaged in domestic service, as *Servant*, *Cook*, *Housemaid*, etc. If occupation has been changed or given up on the day of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, occupation 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," "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.