

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

92

1. PLACE OF DEATH

701

31680

County.....

Registration District No. 100

File No. 8880

Township.....

Primary Registration District No. 5579 Delmar

Registered No. 8880

City *St. Louis* (No. 5579 Delmar) St. Ward

2. FULL NAME

Alfred J. Ewarta

(a) Residence. No. *5579 Delmar Ave* St. *78* Ward. (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: *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 2 1874*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 6 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: *Commercial Traveler*
(b) General nature of industry, business, or establishment in which employed (or employer): *Salumar Granite*
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) *New York* (STATE OR COUNTRY)

10. NAME OF FATHER *Joseph Ewarta*

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

12. MAIDEN NAME OF MOTHER *Lydia Davis*

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

14. INFORMANT *Mildred Ewarta* (Address) *5579 Delmar Ave*

15. FILED *Max C. Starkloff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 19 1919*

17. I HEREBY CERTIFY, That I attended deceased from *June 11 1919*, to *Oct 19 1919*, that I last saw him alive on *Oct 19 1919*, and that death occurred, on the date stated above, at *8:20 P.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of the Bladder (duration) *2000* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Arteriosclerosis* (duration) *10* yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *W. H. Schubert* M. D. , 19 (Address) *2009 E. Grand*

*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 *St. Jefferson Sprague* DATE OF BURIAL *Oct 21 1919*

20. UNDERTAKER *C. R. Lupton* ADDRESS *4449 Olive 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, 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.

1 PLACE OF DEATH

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

 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 93

County
Township or Village or City
Registration District No.
Primary Registration District No.
File No.
Registered No.
St. Ward
If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Alfred J. Everts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH March 25th 1842 (Month) (Day) (Year)
7 AGE 77 yrs. 6 mos. 24 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)

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

X (Informant) Winnie Everts
0 (Address) 5579 Delmar Ave

15 Filed NOV - 5 1919 1917 Max B. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 191..... (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 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

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....
20 UNDERTAKER ADDRESS

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3680
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