63

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

38215

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 10947

Township ..... Primary Registration District No. 1002 Registered No. .....

City St Louis Mo (No. 5005 Robin Ave St. ..... Ward)

2. FULL NAME Charlotte Hildebrand

(a) Residence: No. 5005 Robin Ave St., VA 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 23 1841

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
78	11	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeper
(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) Austria

PARENTS

10. NAME OF FATHER Michael Schuf
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Austria
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Austria

[illegible] Theresa Dollak
[illegible] 5005 Robin Ave

FILE [illegible] Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30th 1919

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1919, to Dec 30, 1919 that I last saw her alive on Dec 30, 1919 and that death occurred, on the date stated above, at 2 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1 70

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J J Burdick, M.D.

, 19 (Address) 2106 E Grand Ave

*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: Calvary
DATE OF BURIAL: Jan 2 1920

20. UNDERTAKER: Math Hermann & Son
ADDRESS: 4103 Florissant Ave

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state [illegible]USE 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 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, Compositor, 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 pneumon*[illegible] *pneumonia* ("Pneumonia," unqualified, [illegible] *Tuberculosis of lungs, meninges, peri*[illegible] *Carcinoma, Sarcoma*, etc., of ..... [illegible] gin; "Cancer" is less definite; avoid [illegible] for malignant neoplasms) *Measles;* [illegible] *Chronic valvular heart disease; C*[illegible] *nephritis*, etc. The contributory [illegible] tercurrent) affection need not be stated [illegible] portant. Example: *Measles* (disease causing death), *39 ds.; Bronchopneumonia* (secondary), *40 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.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMAN

item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho... EATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

ALL NOT RECEIVE A FEE FOR CERTIFICATES INTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

16947

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. .....

City St. Louis (No. 5005 Robin Ave. St. ..... Ward)

2. FULL NAME Maria Hillebrand

(a) Residence. No. 5005 Robin Ave St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	78	11	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(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) Austria

PARENTS

10. NAME OF FATHER Michael Schuf

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Theresa Dollak
(Address) 5005 Robin Ave

15. DEC 31 1919

15. 19

FILED ..... 19 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 30 1919

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw the ..... alive on ....., 19....., and that death occurred on the date stated above, at 2:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

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) ....., M. D

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary	Jan. 2, 1920

20. UNDERTAKER Math. Hermann and Son ADDRESS 4103 West Florissant Ave

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States Standard Certificate of Death

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

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