

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

1. PLACE OF DEATH

County St. Louis Registration District No. 784 File No. 20266
 Township St. Ferdinand Primary Registration District No. 6030 Registered No. _____
 City Jouissance (No. 2416 McLaren) St. _____ Ward _____

2. FULL NAME

Catherine L. Gehm
 (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 Female 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 John J. Gehm

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10th 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
59 8 9

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at Home
 (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) Missouri

10. NAME OF FATHER John Turner

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

12. MAIDEN NAME OF MOTHER Mary Sander

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

14. INFORMANT John J. Gehm (Address) 2416 McLaren av

15. FILED 5-21 1920 Roy Johnson, Jr. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/19/1920

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1920, to 5/19, 1920, that I last saw her alive on 5/17, 1920, and that death occurred, on the date stated above, at 11:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial infarction
436
8289 (duration) 1 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Essential hypertension (duration) _____ yrs. _____ mos. 2 ds.

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

19. DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

20. WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Stethoscope
 (Signed) Dr. Helen Boyd, M. D.
5720, 1920 (Address) 6104 N. Broadway

*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 Cabary DATE OF BURIAL 5-22 1920

20. UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Market

Vol 1535 J. 1-3

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.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County St Louis Registration District No. 784 File No. _____
 Township St Ferdinand Registration District No. 6030 Registered No. _____
 City Fleming Mo. No. _____ St. _____ Ward _____

2. FULL NAME

Catherine L. Gehon
 (a) Residence No. 2416 McLaure Ave Sts. _____ 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-19 19 20

17. I HEREBY CERTIFY, That I attended deceased from _____
5-19 1920 to 8-19 1920
 that I last saw him/her on 3-19 1920, and that death occurred on the date stated above, at 11:50 P.M.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
myocarditis chronic

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 20 1860
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 8 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home (duration) 1 yrs. 0 mos. 0 ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

CONTRIBUTORY (SECONDARY) cerebral thrombosis (duration) _____ yrs. _____ mos. 2 ds.

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

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

DID AN OPERATION PRECEDE DEATH. no DATE OF _____

WAS THERE AN AUTOPSY. no

WHAT TEST CONFIRMED DIAGNOSIS. stethoscope
 (Signed) Dr. R. Silburn Byrd, M. D.
5-20 1920 (Address) 6104 N. Broadway

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PARENTS

10. NAME OF FATHER John Turner
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland
 12. MAIDEN NAME OF MOTHER Mary Seale
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ireland

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary DATE OF BURIAL 5-22 19 20

20. UNDERTAKER Arthur J. Kounelly ADDRESS 2039 Wash St

14. INFORMANT John L. Gehon
 (Address) 2416 McLaure Av

15. FILED 5-21 19 20 Ray Johnson M.D. REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IS IN PINK VERMILION AND MUST BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

SUPPLEMENTARY

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