

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

19328

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Towship..... Primary Registration District No..... Registered No. 6051
City St. Louis..... St. Ward.....

2. FULL NAME

(a) Residence. No. 1302 1/2 Broadway 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>58</u>	<u>-</u>	<u>-</u>	<u>-</u>	

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

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

10. NAME OF FATHER Stephen Rydzik

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

12. MAIDEN NAME OF MOTHER not known

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

14. INFORMANT Eva Rydzik
(Address) 1302 1/2 Broadway

15. FILED 28 1932 Max L. Stark REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 1921

17. I HEREBY CERTIFY, That I attended deceased from July 18 1921 to July 20 1921, 1921, that I last saw him alive on July 20 1921, and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia

(duration) - yrs. - mos. 15 ds.

CONTRIBUTORY (SECONDARY) Operator to original hernia
(duration) 6 yrs. - mos. - ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 19 1921

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) W. A. Mansfield M.D.
, 19 (Address) 913-14 Chemical

*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 FUNERAL, CREMATION, OR REMOVAL St. Peter & Paul DATE OF BURIAL July 28 1921

20. UNDERTAKER Chulick & Co ADDRESS Chulick & Co

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.

United States Standard Certificate of Death

U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of every important, so that the relative of various pursuits can be known. The lies to each and every person, irrespec- For many occupations a single word or first line will be sufficient, e. g., *Farmer or Physician, Compositor, Architect, Locomotive Civil engineer, Stationary fireman*, etc. In special cases, especially in industrial employ- ment, it is necessary to know (a) the kind of work necessary to know the nature of the business or industry, and (b) an additional line is provided for the statement; it should be used only when needed.

(a) *Spinner, (b) Cotton mill; (a) Sales- cery; (a) Foreman, (b) Automobile fac- tory*, etc. Material worked on may form part of the statement. Never return "Laborer," "Fore- man," "Dealer," etc., without more specification, as *Day laborer, Farm laborer, Mine laborer*, etc. Women at home, who are engaged in the duties of the household only (not paid for their services who receive a definite salary), may be reported as *Housewife, Housework or At home*, and gainfully employed, as *At school or At work*, etc. For persons engaged in domestic employ- ment, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on the day of DISEASE CAUSING DEATH, state occu- pation during illness. If retired from busi- ness, it may be indicated thus: *Farmer (re- tired)*.

For persons who have no occupation state *None*.

Statement of cause of Death.—Name, first, last, and middle (the primary affection causing death, with time and causation,) using always the full term for the same disease. Examples: *Scarlet fever* (the only definite synonym is *epidemic cerebrospinal meningitis*); *Diphtheria* ("Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Broncho- pneumonia* ("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 child- birth 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 rail- way 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.

Lobar _____

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

2. FULL NAME

County.....
 Township.....
 City.....
 No.....
 Registration District No.....
 Primary Registration District No.....
 File No.....
 Registered No.....
 Ward.....

(a) Residence, No.....
 (Usual place of abode)
 Length of residence in city or town where death occurred
 yrs..... mos.....
 Sl.....
 Ward.....
 How long in U.S., if of foreign birth?
 yrs..... mos.....
 Sl.....
 Ward.....

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH