

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

**3023**

**1. PLACE OF DEATH**

County..... Registration District No. 70  
 Township..... Primary Registration District No. 70  
 City St Louis (No. 5343 Maple Ave)  
 File No. 3023  
 Registered No. 7811 St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(a) Residence. No. 5343 Maple Ave, 78 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 Wm McB. Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 13 - 1891

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____hra. or _____min.
	<u>70</u>	<u>11</u>	<u>7</u>	

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Butteport Court House  
 (STATE OR COUNTRY) Virginia

10. NAME OF FATHER John Gordon

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

12. MAIDEN NAME OF MOTHER Blacwell

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

14. INFORMANT L. B. Smith  
 (Address) 5922 Gates Ave St Louis

15. FILED \_\_\_\_\_ 19 Mar 6 Starkeoff REGISTERED

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 21 19 22

17. I HEREBY CERTIFY, That I attended deceased from July 20 19 21, to July 21 19 22, that I last saw him alive on July 21 19 22, and that death occurred, on the date stated above, at 10:30 p. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Angina Pectoris  
94 (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? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physician's certificate  
 (Signed) Dr. J. B. ... M. D.

Address 4372 Olive St Jan 21, 1922

\*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 Louis DATE OF BURIAL 1/23 19 22

20. UNDERTAKER M. H. Alexander ADDRESS 2835 Olive St

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association)

Linnell 507

"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 neoplasma); *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.)

Statement of Occupation.—The statement of occupation is very important, so that the relative healthfulness of various pursuits is known. The question applies to each 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.*

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.

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

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

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

**1. PLACE OF DEATH**

County..... Registration District No. 791 File No.....  
 Township St. Louis Primary Registration District No. 1003 Registered No. 731  
 City St. Louis (No. ....) St. .... Ward)

**2. FULL NAME**

Fannie B. Smith

(a) Residence, No. .... St. .... Ward. ....  
 (Usual place of birth) (If nonresident give city or town and State)  
 Length of residence in city or town ..... Birth occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL**

**GENERAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX**

SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan 21 19 22

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

Married

**17. I HEREBY CERTIFY** That I attended deceased from ..... to ..... 19.....

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

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

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above.....  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**8. OCCUPATION OF DECEASED**

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

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

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

**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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PARENTS

**10. NAME OF FATHER**

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

**12. MAIDEN NAME OF MOTHER**

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

**14.**

INFORMANT (Address) .....

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** DATE OF BURIAL

**15.**

FILED May 6 Starneoff REGISTRAR

**20. UNDERTAKER** ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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