

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

8500

1. PLACE OF DEATH

County St. Louis Registration District No. 398 File No. _____
 Township W. 1st Primary Registration District No. 5554 Registered No. 108
 City St. Louis (No. 119 No. 1000000000) St. _____ Ward _____

2. FULL NAME

Luigi G. Slesson
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

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 Mina G. Slesson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 13 - 1889

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
34 | 7 | 15

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

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

10. NAME OF FATHER Franklin Slesson

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

12. MAIDEN NAME OF MOTHER Clara Jones

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

14. INFORMANT (Address) Mina G. Slesson
119 N. Overmont

15. FILED 3/31, 1922 F. L. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 28 1922

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
 (duration) yrs. 6 mos. 7 da.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH... X DATE OF X

WHAT TEST CONFIRMED DIAGNOSIS... System

(Signed) M. J. Slesson, M. D.
3/31, 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 Mt. Washington DATE OF BURIAL 3-31-1922

20. UNDERTAKER Mrs. L. L. Foster ADDRESS White, Mo.

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.

STATE BOARD OF United States Standard
OF VITAL STATISTICS Certificate of Death

Registration District No. S. Census and American Public Health Association.)
 City Registration District No.

St.
 mos. ds.

WIDOWED OR
 (use word)
 LESS than I
 hrs.
 min.

16. DATE OF DEATH

17. I HEARD OF THE DEATH OF THE DECEASED AT THE PLACE WHERE HE LAST SAW HIM

THE CAUSE OF DEATH

CONTRIBUTORY (SECONDARY)

18. WHERE WAS THE DECEASED AT THE TIME OF HIS DEATH

IF NOT AT HOME

DID AN OPERATING DISEASE CAUSING DEATH OCCUR

WAS THERE ANY TEST OF THE DISEASE

(Signed) _____

19. PLACE OF BURIAL

20. UNDERTAKER

REGISTRAR

of Occupation.—Precise statement of very important, so that the relative of various pursuits can be known. The names to each and every person, irrespective of many occupations a single word or short line will be sufficient, e. g., *Farmer* or *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Stationary Fireman*, etc. In special cases, especially in industrial employments, necessary to know (a) the kind of work he nature of the business or industry, an additional line is provided for the purpose; it should be used only when needed. (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*; (a) *Foreman*, (b) *Automobile factory*. Material worked on may form part of the name. Never return "Laborer," "Foreman," "Dealer," etc., without more designation, as *Day laborer*, *Farm laborer*, *at mine*, etc. Women at home, who are not gainfully employed, as *At school* or *At home* should be taken to report specifically names of persons engaged in domestic occupations, as *Servant*, *Cook*, *Housemaid*, etc. If a disease causing death, state occurrence of illness. If retired from business may be indicated thus: *Farmer* (retired). For persons who have no occupation state *None*.

CAUSE OF DEATH.—Name, first, last, and middle (the primary affection), time and causation), using always the term for the same disease. Examples: *Scarlet fever* (the only definite synonym is *rebrospinal meningitis*); *Diphtheria* (*Croup*); *Typhoid fever* (never report

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 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 homicide; Poisoned by carbolic acid—probably*. The nature of the injury, as fracture of skull, or consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by the Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of acceptable 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 the following diseases, without explanation, as the cause of death: Abortion, cellulitis, childbirth, convulsion, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, etc. But general adoption of the minimum list suggested is a vast improvement, and its scope can be extended as desired."

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

FOR MUST BE WRITTE