

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

3512

1. PLACE OF DEATH
 County St. Louis Registration District No. 816 File No.
 Township Chesnut Primary Registration District No. 4492 Registered No. 10
 City St. Louis (No.) St. Ward

2. FULL NAME Concilia Sylvester Kunder
 (a) Residence. No. 1119 Helen St. 1 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 13 yrs. mos. 13 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 13 1903

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>13</u>	

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1923 to Jan 31 1923, that I last saw her alive on Jan 23 1923, and that death occurred, on the date stated above, at 8:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart attack
due to HTA & high blood pressure
 (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Chesnut Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Marshall Kunder

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

12. MAIDEN NAME OF MOTHER Rebecca Kunder

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

CONTRIBUTORY (SECONDARY)

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) E. C. Bennett M. D.
2-1-23 (Address) Chesnut Mo

14. INFORMANT Marshall Kunder
 (Address) Chesnut Mo

15. FILED 2-1-23 E. C. Bennett
 REGISTRAR

*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 Chesnut Mo DATE OF BURIAL Jan 31 1923

20. UNDERTAKER H. F. Kunder ADDRESS Chesnut Mo

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 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.)

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.

1 PLACE OF DEATH

County ScottDEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

Township _____

State of _____

Village _____

Registered No. _____

City Chaffee (No. _____ St.; Ward _____)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Cornelius Sylvester Kinder
419 Nelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)S

6 DATE OF BIRTH

X Jan. 18 1923
(Month) (Day) (Year)

7 AGE

If LESS than
1 day, ____ hrs.
or ____ min. ?

____ yrs. ____ mos. ____ ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed Feb. 1st 1923

1923

G. S. Sample
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 31 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Duration) ____ yrs. ____ mos. ____ ds.Contributory _____
(SECONDARY) _____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____, M. D.

_____, 191____ (Address) _____

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____, 191____

20 UNDERTAKER

ADDRESS

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