

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

6535

1. PLACE OF DEATH

County..... Registration District No. 828
 Townshp. St. Louis Primary Registration District No. 1200
 City St. Louis (No. St. John's Hosp) St. 9 Ward)

File No. _____
 Registered No. 1238

2. FULL NAME

Oscar M. Bilhary
 (a) Residence. Boxer Springs Kas 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. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Blanche Behn Bilhary

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 4 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mining Engineer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY) Montreal Province

10. NAME OF FATHER Oscar Bilhary

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

12. MAIDEN NAME OF MOTHER Prinz Distenoff

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

14. INFORMANT Dr. W. E. Roy
 (Address) Boxer Springs Kas

15. FILED Max B. Starckoff

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 2, 1923

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to Feb. 2, 1923, that I last saw him alive on Feb. 2, 1923, and that death occurred, on the date stated above, at 9.30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Neural Arteriosclerosis
51A
53B
12.2.18 (duration) yrs. mos. 90 ds.
 CONTRIBUTORY Hypertension left Kidney
 (SECONDARY) followed left Engorged Heart
 (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF June 5, 1920
 WAS THERE AN AUTOPSY? No DATE OF June 13, 1923

WHAT TEST CONFIRMED DIAGNOSIS? Drugs & Microscopic Path
 (Signed) J. J. O'Brien, M. D.
 , 19 (Address) 611 Metropolitan Bldg.

*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 Valhalla DATE OF BURIAL Feb. 4, 1923

20. UNDERTAKER Wagoner ADDRESS 3621 Olive

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: "Certificate 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

County _____

791
1003

STANDARD CERTIFICATE OF DEATH

1238

Township _____

State of _____

Village _____

Registered No. _____

City St. Louis

(No. St. John Hospital St.; _____ Ward)

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

2 FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Feb 2, 1923
(Month) (Day) (Year)

6 DATE OF BIRTH Sept 8, 1863
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

7 AGE 59 yrs. 4 mos. 24 ds. If LESS than 1 day, ____ hrs. or ____ min. ?

that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

8 OCCUPATION (a) Trade, profession, or particular kind of work Mining Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:
General Carcinomatosis
Hernia left inguinal
Hernia (Duration) ____ yrs. ____ mos. ____ ds.

9 BIRTHPLACE (State or country) _____

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) _____, M. D.
_____, 191____ (Address) _____

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or country) _____

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (FOR HOSPITAL 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 _____

(Informant) _____
(Address) _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

15 MAR 26 1923
Filed _____, 1923 Mar 6 Starkeoff REGISTRAR

20 UNDERTAKER _____ ADDRESS _____

Important. See instructions on back of certificate.

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