

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

7000

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. 1746  
 City St. Louis Childrens Hospital St. .... Ward)

**2. FULL NAME** Raymond Schlemmer

(a) Residence. No. 2722 So. Seventh St., 3 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

male | white | single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-30-1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
12

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Missouri

10. NAME OF FATHER Elmer Schlemmer

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

12. MAIDEN NAME OF MOTHER Minnie Glencor

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

14. INFORMANT Marie Lavin (Address) 500 So. Kingshighway

15. FILED FEB 15 1923 May G. Starkeoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-15-1923

17. I HEREBY CERTIFY, That I attended deceased from 2-17-1923, to 2-15-1923 that I last saw him alive on 2-15-1923, and that death occurred, on the date stated above, at 4:28 a.m.

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

16 1/2 (duration) yrs. mos. 12 ds.

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

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF 2/12/23

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) E. H. Pabsting M. D. 19 (Address) St. L. Childrens Hosp

\*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 Columbia Ill DATE OF BURIAL Feb 16 1923

20. UNDERTAKER Fritz Brown ADDRESS 2201 50 Grand

PARENTS

# 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, Composer, 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.

1746

County .....

## STANDARD CERTIFICATE OF DEATH

Township .....

State of .....

Village .....

Registered No. ....

City *St. Louis* (No. *Children Hosp.* St.; ..... Ward)

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

2 FULL NAME *Raymond Schlemmer**2722 So. Brent*

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

3 SEX *M* 4 COLOR OR RACE *W* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)16 DATE OF DEATH *Oct 15*, 19*23*  
(Month) (Day) (Year)6 DATE OF BIRTH *Jan 30*, 19*23*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...

7 AGE ..... yrs. .... mos. *12* ds. IF LESS than 1 day, .... hrs. or .... min. ?

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

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

The CAUSE OF DEATH\* was as follows:

*Cerebral Hemorrhage*  
*(Birth)*  
*Craniotomy Exploratory*  
*in effort to locate clot*  
Contributory information given on phone by *Dr. H. Hollifield*, M. D.  
*841 Div of S.*

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) .....

\* 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 (Informant) ..... (Address) .....

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 .....

15 *MAR 27 1923* *Max C. Starckoff* REGISTRAR19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL ..... 191...  
20 UNDERTAKER ..... ADDRESS .....

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