

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

1. PLACE OF DEATH.

County.....
Township.....
City.....

Registration District No. 822
Primary Registration District No. 1007
Name Barnes Hosp.

File No. 7221
Registered No. 1990
St. Ward)

2. FULL NAME

Ambrose Bostwick

(a) Residence. No. Renault Ill St. 10 Ward. Renault Ill.
(Usual place of abode)

Renault Ill.
(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nov 5 1877 Married</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS <u>45</u>	MONTHS <u>3</u>
	DAYS <u>15</u>	IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work Oiler
(b) General nature of industry, business, or establishment in which employed (or employer) Rolling Mills
(c) Name of employer Granite City

9. BIRTHPLACE (CITY OR TOWN) Renault Ill
(STATE OR COUNTRY)

10. NAME OF FATHER James Bostwick

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

12. MAIDEN NAME OF MOTHER Irish

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

14. INFORMANT Mary Bostwick
(Address) 209 - 24 St. Granite City

15. FILED FEB 23 1923 Marie Starisoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 20 19 23

17. I HEREBY CERTIFY, That I attended deceased from 2-10 19 23, to 2-20 19 23
that I last saw him alive on 2-20 19 23, and that death occurred, on the date stated above, at 6:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of larynx
47A

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

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) B. L. Busche M. D.
, 19 (Address) Barnes Hospital

*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 Renault Ill DATE OF BURIAL 2-22-1923

20. UNDERTAKER: C. S. Dasher ADDRESS Renault Ill

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," "Anomia" (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 -----
 Township -----
 or -----
 Village -----
 or -----
 City St. Louis (No. -----, St.; Ward -----)

 DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

1990

State of -----

Registered No. -----

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

2 FULL NAME

Ambrose Bastwick

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH X Nov 5 1897 X
 (Month) (Day) (Year)

7 AGE ----- yrs. ----- mos. ----- ds. If LESS than 1 day, ----- hrs. or ----- min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Roller Rolling Mills
 (b) General nature of industry, business, or establishment in which employed (or employer) Granite City

9 BIRTHPLACE (State or country)

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

Jan 26 1923 Max B. Starkeoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 20 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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