

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

13946

1. PLACE OF DEATH

County..... Registration District No. 781 File No.
 Township..... Primary Registration District No. 7000 Registered No. 3485
 City St. Louis (No. 785 Council 3rd Ward)

2. FULL NAME

Mary M. Barley
 (a) Residence. No. 785 Euclid Ave. St. 9 Ward. (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

MEDICAL CERTIFICATE OF DEATH

2

3. SEX Female **4. COLOR OR RACE** Wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 4 1923

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

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1922, to Apr 4, 1923.
 that I last saw h. alive on Apr 3, 1923, and that death occurred, on the date stated above, at 8:30 AM

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 20 - 1857

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 1 17

Cystic Fibrosis of Intestine
48 (duration) yrs. mos. ds.
 CONTRIBUTORY Influenza (SECONDARY) (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

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

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER David Drees

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

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

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Mary Black

WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination
 (Signed) Dr. Robert L. ... M. D.
 , 19 (Address) 903 Amberbaum

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

*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.)

14. INFORMANT (Address) Norman McBarley
785 Euclid Ave.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL (DATE OF BURIAL) Christophersville Apr 19 23

15. FILED Mar 6 1923 St. Louis

20. UNDERTAKER (ADDRESS) Wm. H. Stewart 5523 Easton

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.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

M. 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. See instructions on back of certificate.

1 PLACE OF DEATH

County St. Louis
Township _____
or _____
Village _____
or _____
City St. Louis (No. _____ St.; _____ Ward)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

3485

791
1002

REGISTERED No. _____
[If death occurred in a hospital or institution, give its NAME instead of street and number.]
SUPPLEMENTAL

2 FULL NAME

Nancy J. M. Poppley
785 Gaudin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH _____, 1923
(Month) (Day) (Year)

6 DATE OF BIRTH Feb 22, 1857
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

7 AGE 66 yrs. 1 mo. 12 ds. If LESS than 1 day, ____ hrs. or ____ min. ?

The CAUSE OF DEATH* was as follows:
Cystic Tumor of Ovaries
Malignant. Information given
over phone by Dr. N. L. Tolach
surv. of U.S. (Duration) _____ yrs. _____ mos. _____ ds.

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

9 BIRTHPLACE (State or country) _____

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

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 FILED NOV 16 1923
Max B. Starceoff
REGISTRAR

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
20 UNDERTAKER _____ ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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