

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

14190

1. PLACE OF DEATH

St. Louis Childrens Hospital

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. 13744
City St. Louis (Name St. Louis Childrens Hospital) (Street St. Louis) (Ward)

2. FULL NAME Eugene Belter

(a) Residence No. 3922 Jennings Rd. Pinckney St. 9 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 9 mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (single the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-7-1917

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 9

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)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER William Belter
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Bernell Basch
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo.

14. INFORMANT M. Bruce (Address) 502 So. Kings highway

15. FILED APR 22 1923 Max E. Starroff REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 04-10-1923

17. I HEREBY CERTIFY, That I attended deceased from 4/7/23, 1923, to 4/10/23, 1923, that I last saw h. alive on 4/10/23, 1923, and that death occurred, on the date stated above, at 2:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Adventitious Cervical Apparatus
Pharyngitis, Pyococcus
115
101
36
(duration) yrs. mos. 14 da.

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

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS:

(Signed) Dr. Hartman, M. D. (Address) St. Louis Childrens 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 DATE OF BURIAL

Calvary Cemetery April 12th 1923

20. UNDERTAKER ADDRESS

Geo. Ringhauer 4102 Manchester

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 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 St. Louis 791
1003

Township _____

or _____

Village _____

or _____

City St. Louis (No. _____)

(St. _____ Ward _____)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

3744

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. _____

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

2 FULL NAME Eugene Belter (Belter)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>July 7</u> (Month) (Day) (Year)		
7 AGE <u>4</u> yrs. <u>9</u> mos. <u></u> ds. or <u></u> min. ? If LESS than 1 day, --- hrs.		

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)

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 JUN 14 1923 May C Starkeoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
April 10 1923
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from 4-7, 1923, to 4-10, 1923, that I last saw him alive on 4-10, 1923, and that death occurred, on the date stated above, at 219a m.

The CAUSE OF DEATH* was as follows:

Adenitis Cervical

Suppurative Pharyngitis

Septicæmia Pyæmia

(Duration) yrs. mos. ds.

Contributory (SECONDARY) _____

(Duration) yrs. mos. ds.

(Signed) D. F. Hartmann, M. D.

_____, 1923 (Address) Children's Hosp

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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

20 UNDERTAKER

ADDRESS

Important! See instructions on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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