

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

14537

**1. PLACE OF DEATH**

County..... Registration District No. 891  
 Township St. Louis Primary Registration District No. 1003 File No. ....  
 City St. Louis (No. Barnes Hospital) Registered No. 4125  
 St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 336 Hawthorne St. Webster Ward Gravois  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 5 yrs. mos. ds. 9 How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</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>Arthur Wayne Green</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 10-1890</u>		
7. AGE <u>33</u>	YEARS <u>1</u>	MONTHS <u>12</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at Home</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>-</u> (c) Name of employer <u>-</u>		

**5 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 22 1923

17. I HEREBY CERTIFY That I attended deceased from Mar 26, 1923 to April 22, 1923 that I last saw him alive on April 22, 1923 and that death occurred, on the date stated above, at 1:00 p.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Paralytic Flu  
139 B  
122 B  
199 B (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY)  
Chronic Pelvic Peritonitis (duration) yrs. mos. 28 ds.

PARENTS

9. BIRTHPLACE (CITY OR TOWN) Webster Gravois  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Nasace A. Sanders

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Webster Gravois  
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Julia B. Bell

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

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

19. DID AN OPERATION PRECEDE DEATH? yes DATE OF April 18, 1923

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) H. H. Keyser, M. D.  
 , 19 (Address) Waller Bldg, St. Louis

\*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 Arthur W. Green  
 (Address) 336 Hawthorne

15. FILED APR 23 1923 May C. Starckoff  
 Registrar

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bellefontaine DATE OF BURIAL Apr 23 1923

20. UNDERTAKER Parker and Co ADDRESS Webster Gravois

# 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: "Certificate, will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, collulitis, 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

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City St. Louis (No. \_\_\_\_\_)DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

## STANDARD CERTIFICATE OF DEATH

4125

State Mo. Registered No. \_\_\_\_\_

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

## 2 FULL NAME

Marion Leontine Green

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)6 DATE OF BIRTH March 10, 1890  
(Month) (Day) (Year)7 AGE 33 yrs. 1 mo. 12 ds. If LESS than 1 day, \_\_\_\_ hrs. \_\_\_\_ min. ?

## 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)

removal of left fallopian tube & ovary for infected10 NAME OF FATHER Dr. J. Roydon11 BIRTHPLACE OF FATHER (State or country) Narmatocete

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 May 6 Stark Coff

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 22, 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:

non Purperal  
non Traumatic  
cause unknown  
infirmation given on phone  
Dr. J. Roydon 6-15-23  
removal of left fallopian tube & ovary for infected

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

## 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 \_\_\_\_\_

REGISTRAR

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