

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

Do not use this space.

22499

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. **6448**
City..... **St. Louis Mo Baptist Sant** St. Ward.....

2. FULL NAME

Clude William
(a) Residence. No. **4503 Chamberlain 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

3. SEX **Male** 4. COLOR OR RACE **Wh** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Apr 28 - 1903**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— 2 16

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER **Dr F O Hillman**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ferryville Mo**

12. MAIDEN NAME OF MOTHER **Josephine Mascher**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ferryville Mo**

14. INFORMANT (Address) **Dr F O Hillman 4503 Chamberlain**

15. FILED **JUL 19 1923** 19. **maile Starreff**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 4 19 23**

17. I HEREBY CERTIFY That I attended deceased from **June 28, 1923, July 4, 1923** and that I last saw him alive on **July 3, 1923** and that death occurred, on the date stated above, at **3 PM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sapraemia
176
36
(duration) **1 1/2** yrs. mos. **3** ds.
CONTRIBUTORY **Infection of eye**
(SECONDARY) **from insect bite**
(duration) yrs. mos. **6** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? **Home**

DID AN OPERATION PRECEDE DEATH? **No.** DATE OF

WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical - Lab.**

(Signed) **Dr F O Hillman**, M. D.

7/4, 1923 (Address) **4503 Ferry Ave.**

*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 **July 4 19 23**

20. UNDERTAKER ADDRESS **St. Stuart** **5325** **Easton**

REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly translated. 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*; *Br pneumonia* ("Pneumonia," unqualified, is indel *Tuberculosis of lungs, meninges, peritoneum Carcinoma, Sarcoma*, etc., of. (nam gin; "Cancer" is less definite; avoid use of "T for malignant neoplasma"); *Measles, Whooping Chronic valvular heart disease; Chronic inter nephritis*, etc. The contributory (secondary terourrent) affection need not be stated unless portant. Example: *Measles* (disease causing d 29 ds.; *Bronchopneumonia* (secondary), 1 Never report mere symptoms or terminal cond: such as "Asthenia," "Anemia" (merely sym atio), "Atrophy," "Collapse," "Coma," "C sions," "Debility" ("Congenital," "Senile," "Dropsy," "Exhaustion," "Heart failure," " orrhage," "Inanition," "Marasmus," "Old "Shock," "Uremia," "Weakness," etc., w definite disease can be ascertained as the Always qualify all diseases resulting from birth or miscarriage, as "PUERPERAL septic "PUERPERAL peritonitis," etc. State caus which surgical operation was undertaken. VIOLENT DEATHS state MEANS OF INJURY and q AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, (probably such, if impossible to determine defir Examples: *Accidental drowning; struck by way train—accident; Revolver wound of h homicide, Poisoned by carbolic acid—probably s The nature of the injury, as fracture of skull consequences (e. g., sepsis, tetanus), may be a under the head of "Contributory." (Recomm tions on statement of cause of death approve Committee on Nomenclature of the Amd Medical Association.)*

NOTE.—Individual offices may add to above list of un able terms and refuse to accept certificates containing Thus the form in use in New York City states: "Certif will be returned for additional information which give a the following diseases, without explanation, as the sole of death: Abortion, cellulitis, childbirth, convulsions, he rhage, gangrene, gastritis, erysipelas, meningitis, miscarr necrosis, peritonitis, phlebitis, pyemia, septicemia, tetar But general adoption of the minimum list suggested will vast improvement, and its scope can be extended at a l date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.