

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

Do not use this space.

22889

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No.....
 City St. Louis (No. Jewish Hosp)..... St. Ward)

File No.
 Registered No. 8908

2. FULL NAME

(a) Residence. No. 2715 Dayton St. 7 Ward.
 (Usual place of abode) (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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
ab 53

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.....

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

10. NAME OF FATHER William Feldman

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

12. MAIDEN NAME OF MOTHER unk

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

14. INFORMANT Morris Feldman
 (Address) 2317 Franklin

15. FILED JUL 19 1923 maye Starneoff
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JUL 19 1923

17. I HEREBY CERTIFY, That I attended deceased from July June
the 27, 1923, to July 19, 1923
 that I last saw her alive on July 19, 1923, and that death occurred, on the date stated above, at 4:45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brain Tumor, Glioma
530

Indefinite (duration) 1 mos. 19 ds.?

CONTRIBUTORY (SECONDARY) 8/1
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 17, 1923

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic Exam. of Tumor

(Signed) C. W. Wilhelm, M. D.
 , 19 (Address) 5415 Helmas, Jewish 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

C. E. SHEL E M E T H

DATE OF BURIAL

19 1923

20. UNDERTAKER

A. B. Berger

ADDRESS

5712 Michigan

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 child-birth 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, 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.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County..... Registration District No. 791 File No. 22889
 Township St. Louis Primary Registration District No. 1003 Registered No. 6908
 City St. Louis (No.) St. (Word)

2. FULL NAME

Sarah Grober

(a) Residence. No. St. Ward.
 (Usual place of abode) (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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M.</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
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) (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1923

17. I HEREBY CERTIFY, That I attended deceased from to that I last saw him and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brain tumor Glioma
Medical information given over
phone by Dr. E. M. Wilhelm 3-20-23
per 9/20/23

CONTRIBUTORY (SECONDARY) 44

18. WHERE WAS DISEASE CONTRAICTED
 IF NOT AT PLACE OF DEATH? Yes DATE OF July 17, 1923

DID AN OPERATION PRECEDE DEATH? Yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.
 , 19 (Address)

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SUPPLEMENTARY

14. INFORMANT (Address)

15. FILED 1 19 Mar 6 1923 Registrar

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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