

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

Do not use this space.

2210

3

1. PLACE OF DEATH
 County St. Louis Registration District No. 1160
 Township Central Primary Registration District No. 4470
 City University (No. 6651) Washington ave. St. _____ Ward _____
 Registered No. _____
 2. FULL NAME Jane Smith
 (a) Residence University 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Smith
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1, 1837
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 | 8 | 8 | _____ day, _____ hrs. or _____ min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House work
 (b) General nature of industry, business, or establishment in which employed (or employer) at home
 (c) Name of employer _____
 9. BIRTHPLACE (CITY OR TOWN) Belfast
 (STATE OR COUNTRY) Ireland
 10. NAME OF FATHER John McQuoid
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Not known
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ireland
 (STATE OR COUNTRY) _____
 14. INFORMANT Miss Jennie Smith
 (Address) 6651 Washington
 15. FILED 1-9-24 19. Joel H. Sutter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1924
 17. I HEREBY CERTIFY That I attended deceased from Dec 11, 1923 to Jan 4, 1924 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 2:45 a. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sup. of Arteries
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Emphy
 (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Arthur M. D.
1-10-24 (Address) 10th 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 Valhalla Cemetery DATE OF BURIAL Jan 10 1924
 20. UNDERTAKER Edna Shepard ADDRESS 5921 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, 8 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.

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

1. PLACE OF DEATH

County St. Louis Registration District No. 1160 File No. 3
 Township Central Primary Registration District No. 4470 Registered No.
 City St. Louis No. 6651 Washington Ave St. Ward (If nonresident give city or town and State)

2. FULL NAME

(a) Residence No. Jane Smith St. Ward
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1837

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 8 8

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) Belfast
 (STATE OR COUNTRY) Ireland

PARENTS

10. NAME OF FATHER Jos M. Quinn

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

12. MAIDEN NAME OF MOTHER Quinn

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

14. INFORMANT Miss Jennie Smith
 (Address) 6651 Washington Ave

15. FILED 1-10 19 24 Jos H. Sutter
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 19 24

17. I HEREBY CERTIFY, That I attended deceased from to 19....., that I last saw him 19....., and that death occurred, on the date named above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia
hypostatic
Lobar Pneumonia
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Senility
 (duration) yrs. mos. ds. 28

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

DID AN OPERATION PRECEDE DEATH? no DATE OF OPERATION 10/10/24

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) C. A. Ambrose, M. D.
 (Address) Lister Bldg
1-10, 19 24

*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 Valhalla DATE OF BURIAL Jan 10 - 1924

20. UNDERTAKER Clara Shepard ADDRESS 5921 Easton Ave

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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