

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

Do not use this space.

5944

1. PLACE OF DEATH

County..... Registration District No. 791
 Township.....St. Louis Precinct-Registration District No. 1005
 City.....St. Louis (No. St. Mary)
 File No.
 Registered No. 1598
 St. Ward

2. FULL NAME

Freda (Satary) Sartory

(a) Residence. No. 6834 Balcon St. 10 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6 - 1905

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 5 75

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk
 (b) General nature of industry, business, or establishment in which employed (or employer) Forest Paper Co
 (c) Name of employer

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

10. NAME OF FATHER Jacob Sartory

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

12. MAIDEN NAME OF MOTHER Mary Anghie

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

14. INFORMANT Mary Sartory
 (Address) 6834 Balcon

15. FILED 19 1924 Mar 6 Starceoff
 RECEIVED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/26 1924

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1923, to Feb 13, 1924 that I last saw her alive on Feb 13, 1924, and that death occurred, on the date stated above, at 10:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Parenchymatous Nephritis
133
130 10/A

CONTRIBUTORY (SECONDARY) Lobar Pneumonia
 (duration) yrs. mos. ds. 4

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? Sartory pap.
 (Signed) P. B. Blackburn, M. D.

Feb 15, 1924 (Address) 1536 Paper st.

*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 St. Peter & Paul DATE OF BURIAL 2-16-1924

20. UNDERTAKER Kloemker & Sons ADDRESS 3763 A Grand

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 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.

date death not 2-20-24

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County _____ Registration District No. 791
 Township St Mary Hosp Primary Registration District No. 1003
 City St Mary Hosp (No. St Mary Hosp) St. _____ Ward _____

File No. _____
 Registered No. 1598

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 13, 1924

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said

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

to have occurred on the date stated above, at _____ m.

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

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Name of operation _____ Date of _____

FATHER 13. NAME _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____

MOTHER 15. MAIDEN NAME _____

Where did injury occur? _____ (Specify city or town, county, and State)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Specify whether injury occurred in industry, in home, or in public place. _____

17. INFORMANT (ADDRESS) _____

Manner of injury _____

18. BURIAL, CREMATION, OR REMOVAL

Nature of injury _____

PLACE _____ DATE _____, 19____

24. Was disease or injury in any way related to occupation of deceased? _____

19. UNDERTAKER (ADDRESS) _____

If so, specify _____

20. FILED 10-22-34 J. Bredich Registrar.

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

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

5944