

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

Do not use this space.

10327

**1. PLACE OF DEATH**

County Buchanan Registration District No. 85 File No. 459  
 Township St. Joseph Primary Registration District No. 2 Registered No. 459  
 City St. Joseph (No. 1301) (Hospital 2) St. 1301 Ward 2

**2. FULL NAME**

(a) Residence. No. St. Joseph 1301 St. 2019 Ward 2  
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. J. H. Lewicki

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5<sup>th</sup> 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 74 10 7

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work RR worker  
 (b) General nature of industry, business, or establishment in which employed (or employer) In Record & Board house  
 (c) Name of employer house

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

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT (Address) Miss J. Record

15. FILED 4/15 1924 Wm. Harrison REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 1924

17. I HEREBY CERTIFY, That I attended deceased from March 20 1924 to April 12 24 1924  
 that I last saw him alive on 4/7/24 1924, and that death occurred, on the date stated above, at 6:10 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Cystitis  
(Bladder)

CONTRIBUTORY (SECONDARY) Resident in RR Board house

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF...  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS...  
 (Signed) G. S. Roberts, M. D.  
4/14, 1924 (Address) State Hosp # 2

\*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  
Belmont Cem 4/15 1924

20. UNDERTAKER ADDRESS  
J. H. Murphy 216 001024

PARENTS

# 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

71107 1081  
"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.

## PERSONAL HISTORY

Up to 25 years ago this patient was a strong, healthy, hard working man. He worked in the Railroad Round House. He had never had any serious illness but had a double hernia practically all his life. He was very pleasant around his house, a good husband and a kind parent. About this time he was struck by a locomotive and was badly injured-- a large scalp wound, dislocation of right shoulder and several ribs fractured. He was in the hospital from this injury for 18 months, however he did not go to work for 6 months after his release the hospital. During his confinement in the hospital he ran away but was taken back to the hospital and stayed several months more. He afterwards returned to work for the railroad but did not make good and was given successively jobs with less responsibility. Three years ago he was relieved from work and retired on a pension. One year after he had been retired, during a strike and workers were needed, he was called back and put to work. Owing to his enfeebled condition he fell into a pit and injured his spine. He was then sent home. His health and strength steadily declined and last November he had a stroke of paralysis. After his accident he was very irritable cross and hard to please, just the reverse of what he was before.

## PHYSICAL EXAMINATION

In appearance this patient is much older than the given age 75. He has wasted and flaccid muscles. His skin is sallow, dry and cool in a warm room. Lungs negative. Heart struggles but does not show irregularity in radial pulse. A distinct extended sound of the heart can be heard at right of sternum between the 3rd and 4th ribs. Pupils respond readily to light. Knee jerks normal. There is no evidence of paralysis at present time. Bowels normal; Has severe cystitis with frequent urination, highly colored, but free from odor. At times he suffers severely from cystic tenesmus.

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

**1. PLACE OF DEATH**

County Buchanan Registration District No. 83- File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 25-9  
 City St. Joseph (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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)

10. NAME OF FATHER

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 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT \_\_\_\_\_  
 (Address)

15. FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 1924

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic cystitis (Bladder) 1880  
 (duration) \_\_\_\_\_ mos. da.

CONTRIBUTORY Injured in R. R.  
 (SECONDARY) Round house (duration) \_\_\_\_\_ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 265 years ago. Struck by moving saloon cars.  
 IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? 6500 tests  
 (Signed) \_\_\_\_\_, M. D.  
 , 19 \_\_\_\_\_ (Address) St Hospital No 2

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

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