

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

Do not use this space.

12796

**1. PLACE OF DEATH**

County..... Registration District No. 8511 File No. ....  
 Township St. Louis # 6749 Primary Registration District No. 7003 Registered No. 3668  
 City St. Louis (No. 6749 Lindell Blvd. St. Word)

**2. FULL NAME**

Calvin Kreyder Reifsnider

(a) Residence. No. 5749 Lindell Blvd. 9. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married.

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9<sup>th</sup> 1924.

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

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1924, to April 10, 1924 that I last saw him alive on April 10, 1924, and that death occurred, on the date stated above, at 7 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 21 - 1847

THE CAUSE OF DEATH\*\* WAS AS FOLLOWS:  
Lobar pneumonia

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
77 x 20.

CONTRIBUTORY (SECONDARY) 108 / 10 / 14 (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Publisher (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greentown Ohio

DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

10. NAME OF FATHER Joseph Reifsnider

WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination (Signed) M. J. Jennings, M. D.

12. MAIDEN NAME OF MOTHER Annie Kreyder

(Address) 4101 Washington Rd.

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

\*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.)

14. INFORMANT (Address) Arch S. Merrifield 5931 Kingsbury Blvd.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Valhalla Crematory 4/12-1924.

15. APR 16 1924 Maib Starkoff REGISTRAR

20. UNDERTAKER ADDRESS E. R. Lupton 4449 Olive St.

# 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 neoplasia); *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 STATEMENT  
BY PHYSICIAN.

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

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No.....  
 City..... (No. .... St. .... Ward)

**2. FULL NAME**

*Calvin Kryder Reikswider*

(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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 10th 1924*

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

17. I HEREBY CERTIFY, That I attended deceased from *Mar. 1, 1924*, to *April 10, 1924* that I last saw *him* *live* on *April 9, 1924* and that death occurred on the date stated above, at *about 7 a. m.*

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Gaba Pneumonia*

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

CONTRIBUTORY (SECONDARY) .....

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) yrs. mos. da.  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....

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

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

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

10. NAME OF FATHER .....

WAS THERE AN AUTOPSY? *No* .....

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

WHAT TEST CONFIRMED DIAGNOSIS? *Physical examination*  
 (Signed) *M. D. Jennings*, M. D.

12. MAIDEN NAME OF MOTHER .....

*May 26, 1924 (Address) 4101 Washington Pl.*

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

\*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.)

14. INFORMANT *Rich Merrill*  
 (Address) *5931 Kingsbury Blvd.*

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

15. FILED....., 19..... REGISTRAR

20. UNDERTAKER ADDRESS

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. n. b.—Every item of information should be carefully supported. *HOW SHOULD BE STATED: MARRIED, PHYSICIAN*

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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BY PHYSICIAN.

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