

C. K.

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

Do not use this space.

791

10384

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No.....
 City St. Louis Mo (No. St. John's Hospital)..... St. Ward.....

2. FULL NAME

(a) Residence. No. 1627 Ridgeway Drive St. John's Station
 (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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 27th 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 6 3

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) St. Louis Mo
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Dwight Mueller

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

12. MAIDEN NAME OF MOTHER Margaret Roemelt

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

14. INFORMANT George Free
 (Address) 1627 Ridgeway Drive St. John's Sta.

15. FILED 31 1925 Max B. Starkloff REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 30 1925

17. I HEREBY CERTIFY That I attended deceased from Feb 28 1925 to March 30 1925 that I last saw him alive on March 29 1925 at 6:20 P.M. and that death occurred on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute myocarditis
14 (duration) yrs. mos. ds. 7

CONTRIBUTORY (SECONDARY) Appendectomy + 7 mo pregnancy
Hemolytic Strig. Pepsis (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF about Dec 1 - 25

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS... Clinical
 (Signed) W. C. ..., M. D.
 , 19 (Address) Missouri Pkwy

*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 Burials DATE OF BURIAL April 2 1925

20. UNDERTAKER Math Herwardson 4103rd Howard ADDRESS

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 neoplasm); *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 symptomatio), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Infantion," "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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH.

County Registration District No. 791 File No. 10384
 Township Primary Registration District No. 1003 Registered No. 3412
 City St. Louis (No.) St. (Ward)

2. FULL NAME

Mary Elizabeth Free

(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 f 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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)

PARENTS

14. INFORMANT (Address)

15. FILED May 6 1925 Max B. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 30 19 25

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

acute myocarditis

CONTRIBUTORY (duration) yrs. mos. ds. (SECONDARY) appendectomy 47 mos.

Pregnancy, Haemolytic Strep, Septicemia
Operations for ruptured gangrenous

18. WHERE WAS DISEASE CONTRACTED (duration) mos. ds. appendicitis information given over phone by Dr. R. A. Wall
 IF NOT AS PLACE OF DEATH: DID AN OPERATION PRECEDE DEATH? DATE OF 7-17-25 New York U.S.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL WAS THERE AN AUTOPSY? 7-17-25 New York U.S.

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) M. D. , 19 (Address)

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

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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