

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.

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

Do not use this space.

5870

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1123  
 Township Common Primary Registration District No. 648-B  
 City Jefferson Barracks, (No. U.S. Veterans Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. 66  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** ALFRED P. FLAUAUS

(a) Residence. No. 4001 Ashland Ave. St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred un yrs. kn mos. own ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

**5A. IF MARRIED, WIDOWED, OR DIVORCED**  
 HUSBAND OF Mrs. Alfred P. Flauaus  
 (OR) WIFE OF \_\_\_\_\_

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) March 14, 1896

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
1896	29	10	28	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Floor Walker  
 (b) General nature of industry, business, or establishment in which employed (or employer) Famous & Barr Co.  
 (c) Name of employer Famous & Barr Co.

**9. BIRTHPLACE** (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Illinois

**10. NAME OF FATHER** Louis P. Flauaus

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) Illinois  
 (STATE OR COUNTRY) \_\_\_\_\_

**12. MAIDEN NAME OF MOTHER** Margaret Semor

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

**14. INFORMANT** P. E. Johnson Senior Medical Officer  
 (Address) U.S.V. Hosp., Jefferson Barracks, MO

**15. FILED** AB 19 1925  
4/13/26 L. C. Obrock REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) February 12, 1926

**17. I HEREBY CERTIFY**, That I attended deceased from June 1, 1925 to February 12, 1926  
 that I last saw h. lm alive on February 12, 1926, and that death occurred, on the date stated above, at 12:38 P.

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

Chr. Appendicitis

121B  
125B  
129  
 (duration) un yrs. kn mos. own ds.  
**CONTRIBUTORY (SECONDARY)** Abscess sub-diaphragmatic; Probable Abscess of liver; Collapsed right lung  
 (duration) un yrs. kn mos. own ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH... Unknown  
 DID AN OPERATION PRECEDE DEATH... Yes DATE OF June 5, 1925  
 WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Surgical, physical & Laboratory  
 (Signed) H. W. H. [Signature] Senior Medical Officer, U.S.V. Hosp., Jefferson Barracks, Mo.

\*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. Bernard Cemetery DATE OF BURIAL Feb 16 1926

**20. UNDERTAKER** Mrs. M. J. Walsh ADDRESS 701 State St., St. Louis, Ill.  
Mrs. M. J. Walsh

# 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: "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

**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 St. Louis Registration District No. 1123 File No. ....  
 Township..... Primary Registration District No. 6248B Registered No. 66  
 City..... (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 (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)

14. INFORMANT (Address)

15. APR 27 1926 L. C. Abbott REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12 1926

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

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

CONTRIBUTORY (SECONDARY) Chronic glomerulonephritis (duration) yrs. .... da. non-tuberculous (duration) yrs. .... mo. .... da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: 124A

DID AN OPERATION PRECEDE DEATH? DATE

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.

, 19 (Address)

\*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

20. UNDERTAKER ADDRESS

19

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW  
 PHYSICIANS SHOULD STATE EXACTLY. AGE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.  
 CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

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5-5870