

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

- 26788

1. PLACE OF DEATH
 County..... St. Louis, Mo. Registration District No. 1123
 Township..... GARONVILLE Primary Registration District No. 6248 B File No.
 City..... Jefferson Brks, Mo. (No. U.S. Vet. Hosp. Jefferson Brks, Mo. St. Ward) Registered No. 322

2. FULL NAME..... John Keen.
 (a) Residence. No. Jefferson Barracks, Mo. 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 da. How long in U.S., if of foreign birth? --- yrs. --- mos. --- da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male. 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) Jan. 7, 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ----- hrs. or ----- min.
	42	6	29	

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

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

10. NAME OF FATHER Charles Keen.

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

12. MAIDEN NAME OF MOTHER Bell Blackburn.

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

14. INFORMANT H. N. Carter, Associate Medical Officer
 (Address) U.S. Veterans Hospital Jefferson Barracks, Mo.

15. FILED Aug 7 1926 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 6, 1926

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1926, 19... to August 6, 1926, 19... (that I last saw him alive on August 6, 1926, 19... and that death occurred, on the date stated above, at 12:15 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia, lobar, double.

108
101A
 (duration) --- yrs. --- mos. 10 da.

CONTRIBUTORY (SECONDARY) None.
 (duration) --- yrs. --- mos. --- da.

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

DID AN OPERATION PRECEDE DEATH? No. Date of -----

WAS THERE AN AUTOPSY? No.
 WHAT TEST CONFIRMED DURING Examinations, Physical & Laboratory

(Signed) H. V. Barker, Chief Medical Officer, U.S. Vet. Hosp. Jefferson Barracks, Mo.
 *State the DISEASE CAUSING DEATH, or if death 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 Jefferson Barracks, Mo. DATE OF BURIAL Aug 16 1926

20. UNDERTAKER Hospitals U & C ADDRESS 814 1/2 Bldg

877

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: "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.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County ST. LOUIS State ILLINOIS Registered No. 26788
 Township Carondelet or Village _____ or
 City _____ No. U. S. Vet. Hosp. Jefferson Park Ward _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Keen
 (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 M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED S
(Write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Jan 7 - 1884

7 AGE Years 42 Months 6 Days 29
 If LESS than 1 day, --- hrs. of --- min.

8 OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work carlton
 (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) Ind

PARENTS
 10 NAME OF FATHER _____
 11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind
 12 MAIDEN NAME OF MOTHER _____
 13 BIRTHPLACE OF MOTHER (city or town) (State or country) _____

14 Informant (Address) _____

15 Filed _____, 19 _____ REGISTRAR
 11-2184 GOVERNMENT PRINTING OFFICE

1019 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 6 1926 19 _____

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1926, to Aug 6, 1926 that I last saw him alive on Aug 6, 1926 and that death occurred, on the date stated above, at 12-12 p.m.

The CAUSE OF DEATH* was as follows:
Pneumonia Polar
Hyp double
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) none (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? Phys + Lab
 (Signed) H. W. Barber M. D.
 , 19 (Address) U. S. Vet. Hosp. Jefferson Park

* 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
 _____ 19 _____

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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BY PHYSICIAN.

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