

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

Do not use this space.

39946
File No. 11962
Registered No. 11962
Ward

1. PLACE OF DEATH

County: St. Louis Registration District No. 701
Township: Josephine Hospital Primary Registration District No. 10
City: St. Louis (No. 10) Josephine Hospital St. (Ward)

2. FULL NAME

(a) Residence. No. 3639 Minnesota St. 16 Ward.

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. (If nonresident give city or town and State)

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: Frank Suda

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 5 - 1867

7. AGE: YEARS 59 MONTHS 10 DAYS 11
If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: (a) Trade, profession, or particular kind of work: Housewife
(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: St. Louis MO

10. NAME OF FATHER: Joseph Schwarz

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

12. MAIDEN NAME OF MOTHER: Mary Maeha

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

14. INFORMANT: Frank Suda
(Address) 3639 Minnesota

15. FILED: May 6 1926
19: May 6 1926 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 16 1926

17. I HEREBY CERTIFY, That I attended deceased from May 7th 1926, to Dec 16th 1926, that I last saw her alive on Dec 16th 1926, and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Causes of the Bacterial Meningitis - Operative and Post-operative
7 days after operation to recover (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Absolute closure of the intestine by the cancer (duration) yrs. mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED: If NOT AT PLACE OF DEATH: At her home.

19. DID AN OPERATION PRECEDE DEATH: Yes DATE OF: 16th of Dec.

20. WAS THERE AN AUTOPSY: No

WHAT TEST CONFIRMED DIAGNOSIS?: Inspection of the tissues of the brain
(Signed) J. W. Wilson, M.D.
17th of Dec. 1926 (Address) 2266 S. Crockett

*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: St. Peter & Paul Dec 20 1926

20. UNDERTAKER ADDRESS: Thos. A. Dittus 2406 Gravois

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.

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; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "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.

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

39946.

1. PLACE OF DEATH

County Registration District No. 797
Township Primary Registration District No. 19A
City Josephine Hospital

File No.
Registered No. 11962
St. Ward)

2. FULL NAME

(a) Residence. No. 3639 Minnesota St. 16 Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

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 Frank

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-5-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 10 11

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

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

10. NAME OF FATHER Joseph H. Schwarz

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

12. MAIDEN NAME OF MOTHER May Macla

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

14. INFORMANT Frank Suda
(Address) 3639 Minnesota

15. FILED 12-18 1926 May 6 Starkloff REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 26

17. I HEREBY CERTIFY, That I attended deceased from 5-7 1926, to 12-16 1926, that I last saw h. alive on 12-16 1926, and that death occurred, on the date stated above, at 6 20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of sigmoid flexure

CONTRIBUTORY (SECONDARY) Toxemia
closure of Intestines by Cancer (duration) 14 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 12-16-26
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Geo W. Bock M. D.

1217-1926 (Address) 226 1/2 S Compton

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Peter & Paul DATE OF BURIAL 12-20-26

20. UNDERTAKER Thos Kutie ADDRESS 2506 Graven

N. B.—Every item of information should be carefully supplied. AGE and SEX MUST BE EXACTLY. PHYSICIAN'S SIGNATURE NECESSARY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

PARENTS

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

1. PLACE OF DEATH

County.....
Township.....
City..... (No.) St.
Registration District No.
Primary Registration District No.

File No.
Registered No. **9568**
St. Ward

2. FULL NAME

(a) Residence, No. St. Ward

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

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
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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. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. da.

- IF NOT AT PLACE OF DEATH..... DATE OF.....
- DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
- WAS THERE AN AUTOPSY?.....
- WHAT TEST CONFIRMED DIAGNOSIS..... (Signed)....., M. D.

*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.

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

20. UNDERTAKER ADDRESS