

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

Do not use this space.

40220

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis (No. Mo. 1st Sani) St. \_\_\_\_\_ Ward \_\_\_\_\_  
Registered No. 12256

**2. FULL NAME**

(a) Residence. No. Anglum Mo. St. 12 Ward. St. Louis, Mo.  
(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | White | Married

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

Herman Eilers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 - 1885

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

41      5      4

**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. Louis Co. Missouri  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jacob Bill

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

12. MAIDEN NAME OF MOTHER Anna Hoffman

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

14. INFORMANT Mrs. Herman Eilers  
(Address) Anglum Missouri

15. FILED DEC 21 1926 Max Starckoff  
19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1926

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1926, to Dec 24 1926, that I last saw her alive on Dec 24 1926, and that death occurred, on the date stated above, at 6:30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis  
(duration)..... yrs. 6 mos. da.

CONTRIBUTORY (SECONDARY) Tubercular  
Non Malignant (duration) 1 yrs. mos. da.

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

1 DID AN OPERATION PRECEDE DEATH? Yes. DATE OF 12-19-26

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) A. R. G. M. D.

1725, 1926 (Address) 1500 W. Audubon

\*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. Paul Cemetery DATE OF BURIAL Dec 27 1926

20. UNDERTAKER Geo. L. Pleitach ADDRESS 5966 Easton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state N. E. Every item of information should be carefully supplied. AGE should be stated EXACTLY.

# 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 factor*. 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, Ship 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 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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....

Registration District No. 791

File No.....

Township.....

Primary Registration District No. 1003

Registered No. 12256

City ST. LOUIS (No. ....) St. ....

Ward) .....

**2. FULL NAME**

Catherine M. Eilers

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 19 36

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

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 .....

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

Chronic myocarditis

8. OCCUPATION OF DECEASED

Fibroid tumor  
of the uterus  
Information given over phone by M.T.

(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

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

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

DID AN OPERATION PRECEDE DEATH? DATE OF .....

10. NAME OF FATHER

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

(Signed) ..... M. D.  
19 (Address) .....

12. MAIDEN NAME OF MOTHER

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 (Address)

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

15. FILED 19 May 6 1937 Registrar

20. UNDERTAKER ADDRESS

CAUSE OF DEATH REGISTERED  
USE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS P. 5C  
Exact statement of OCCUPATION  
that it may be properly classified.

SUPPLEMENTARY

S-40220