

STANDARD CERTIFICATE OF DEATH

22434
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County St. Louis, State Missouri 1123 Registered No. 267
 Township Jefferson Barracks, Mo. or Village 6248 or
 City Jefferson Barracks, Mo. No. H Station Hospital, Jefferson Barracks, Mo. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Leah Ross

(a) Residence. No. Jefferson Barracks, Mo. St. _____ Ward. _____
(Usual place of abode)
 Length of residence in city or town where death occurred yrs. 2 mos. _____ ds. _____
(If nonresident give city or town and State)
 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 Widowed
(or) WIFE of Capt. Glenn A. Ross, 6th Inf.

6 DATE OF BIRTH (month, day, and year) March 1, 1893

7 AGE Years 38 Months 4 Days 16
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) Seattle
(State or country) Washington

10 NAME OF FATHER Glenn Albert

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Unknown

14 Informant Capt. Glenn A. Ross, 6th Inf.
(Address) Jefferson Barracks, Mo.

15 Filed July 18, 1927 L. C. Obrock REGISTRAR
11-3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1927

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1927 to July 17, 1927,
 that I last saw her alive on July 17, 1927,
 and that death occurred, on the date stated above, at 4:20 PM

The CAUSE OF DEATH* was as follows:

Sinus thrombosis, cavernous.

[Handwritten signature]

CONTRIBUTORY Rhuncle, nasal cavity, left.
(SECONDARY)

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

Did an operation precede death? Yes Date of July 16, 1927

Was there an autopsy? No
Above symptoms and operation

What test confirmed diagnosis? _____
(Signed) E. L. Moore, Capt. MC, M. D.

, 19 (Address) 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 _____ DATE OF BURIAL _____

National Life Ins Co July 19 1927

20 UNDERTAKER _____ ADDRESS _____

W. H. Moore & Co 787 Pds Bldg

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 OCCURANCE is very important. See instructions on back of certificate.

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 neoplasms); *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 symptom-

atic), "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, plebitis, 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.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.