

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

Do not use this space.

34674

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1123 File No. \_\_\_\_\_  
 Township Carondelet Primary Registration District No. 6248B Registered No. 412  
 City Jefferson Barracks, Mo. U.S. Veterans' Hospital, Jefferson Barracks, Mo. (Ward)

**2. FULL NAME** Peter D. Ewert.

(a) Residence No. 4326 W. Papin Str. St. St. Louis, Mo. Ward. \_\_\_\_\_  
 (Usual place of abode) St. Louis, Mo. Medical Officer In Charge.  
 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 (OR) WIFE OF Mrs. Peter D. Ewert.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 18, 1893

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	34	2	4	

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

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

10. NAME OF FATHER Unavailable.

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

12. MAIDEN NAME OF MOTHER Unavailable.

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

14. INFORMANT G. W. Kleinhoff, Medical Officer.  
 (Address) U.S. Veterans' Hospital, Jefferson Barracks, Mo.

15. FILE NO. 23 REGISTRAR L. C. Obrock, M. D.

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 22, 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1927, to Nov. 22, 1927, that I last saw him alive on Nov. 22, 1927, and that death occurred, on the date stated above, at 2:30 PM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Ureteritis, acute, right, with Thrombosis of ureteral veins and extravasation of blood.

(duration) undetermined. da.  
 CONTRIBUTORY (SECONDARY) Hemorrhage, retroperitoneal.  
 (duration) --- yrs. --- mos. 3 da.

18. WHERE WAS DISEASE CONTRACTED St. Louis, Mo.  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy, Physical & Laboratory findings.  
 (Signed) G. W. Kleinhoff, M. D.  
U.S. Veterans' Hospital, Jefferson Barracks, Mo.

\*State the DISEASE CAUSING DEATH, of 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 National Cemetery DATE OF BURIAL Nov 25 1927

20. UNDERTAKER Hoffmeister U & Co 7814 So Bldg ADDRESS \_\_\_\_\_

R. 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, 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, 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; 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 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," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PURPERAL septicæmia*," "*PURPERAL 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, pyæmia, septicæmia, 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

NOV 26 1897

**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  
Township Carondelet  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 1123  
Primary Registration District No. 6248B

File No. \_\_\_\_\_  
Registered No. 712  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Peter D. Ewert

(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 (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.**

FILED SEP 22 1928 L. C. Obrock, M.D. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 22 1927

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

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

Unrelieved acute right ventricular thrombosis, purulent veins and extravasation of blood (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) hemorrhage, retroperitoneal (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

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.

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

19

20. UNDERTAKER

ADDRESS \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK THIS IS A PERMANENT RECORD

N. B. - This form is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death. It is very important that it be filled out correctly and that it be properly classified. The cause of death should be stated in plain, simple language.

REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THE REG. COM. IS RESCRIBED BY LAW

SUPPLEMENTARY

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