

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

2719

1. PLACE OF DEATH
 County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1008 Registered No. 289
 City St. Louis (No. Barnes Hospital) St. _____ Ward _____

2. FULL NAME West, Newman
 (a) Residence, No. _____ St. 12 Ward Ellington 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 and in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (<i>write the word</i>) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF _____ (OR) WIFE OF <u>Theresa West</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct 28, 1868</u>				
7. AGE	YEARS <u>59</u>	MONTHS <u>2</u>	DAYS <u>10</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED <u>23A</u>				
(a) Trade, profession, or particular kind of work <u>25</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) <u>12th</u>				
(c) Name of employer _____				
9. BIRTHPLACE (CITY OR TOWN) <u>Irving Summit</u> (STATE OR COUNTRY) <u>Mo.</u>				
PARENTS	10. NAME OF FATHER <u>West</u> <u>Fred W. Newman</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>MO</u>			
	12. MAIDEN NAME OF MOTHER <u>unborn</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>MO.</u>			
14.	INFORMANT <u>Joseph Melt</u> (Address) <u>Clayton Mo.</u>			
15.	FILED <u>Jan 6 1928</u> <u>James B. Starrey</u> REGISTRAR			

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>Jan 8 1928</u>	17. I HEREBY CERTIFY, That I attended deceased from _____ <u>12-19-19</u> , to <u>1-8</u> , 19 <u>28</u> that I last saw h. <u>alive</u> on <u>1-8</u> , 19 <u>28</u> , and that death occurred, on the date stated above, at <u>4:45 A.M.</u>
THE CAUSE OF DEATH* WAS AS FOLLOWS: <u>Tuberculosis, Chronic, Far-Advanced</u> <u>Pulmonary, Intestinal,</u> <u>Laryngeal</u> (duration) <u>Many</u> yrs. _____ mos. _____ ds.	
CONTRIBUTORY (SECONDARY) <u>Peritonitis, Pleuric following</u> <u>Intestinal perforation</u> (duration) _____ yrs. _____ mos. <u>1</u> ds.	
18. WHERE WAS DISEASE CONTRACTED _____ IF NOT A PLACE OF DEATH? _____	
DID AN OPERATION PRECEDE DEATH? <u>No.</u> DATE OF _____	
WAS THERE AN AUTOPSY? <u>Yes</u>	
WHAT TEST CONFIRMED DIAGNOSIS? <u>Sputum, X-Ray,</u> <u>Post-mortem Finding</u> (Signed) <u>R. C. Brewer</u> , M. D. <u>1-8, 1928</u> (Address) <u>Barnes Ho</u>	
*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 <u>Pacific Mo.</u>	DATE OF BURIAL <u>Jan 10 1928</u>
20. UNDERTAKER <u>Bauman Bros</u>	ADDRESS <u>Cleveland Park - Mo</u>

Standard

Public Health

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Examples:
synonym is
; *Diphtheria*
(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.; *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.