

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County St. Louis
Township Central
or
Village
or
City

Registration District No. 790 File No. 7918
Primary Registration District No. 6033A Registered No. 37
(NO. St. Vincent's Asylum St. _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Frederick W. Duckworth

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Married
MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH April 18, 1868
(Month) (Day) (Year)
AGE 47 yrs. 10 mos. 2 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work Railroad Agent
(b) General nature of industry, business, or establishment in which employed (or employer) S. C. R. R.

BIRTHPLACE (City or town, State or foreign country) Illinois 4-6-6

PARENTS
NAME OF FATHER Aaron Duckworth
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Eliz. Crossen
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. W. Duckworth
(ADDRESS) Pinckneyville

Filed 2/20 1911 Reba Glenn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 20, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 14, 1911, to Feb. 20, 1911, that I last saw him alive on Feb. 20, 1911, and that death occurred, on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:
Congestion of Brain
6-2-11

Contributory Acute Mania
(SECONDARY) (Duration) yrs. mos. 7 ds.
(Signed) F. W. Hornum M. D.
Feb. 20, 1911 (Address) 3654 Delaware Av.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.
Where was disease contracted If not at place of death?
Former or usual residence New Athens

PLACE OF BURIAL OR REMOVAL New Athens Ill DATE OF BURIAL 2/21 1911

UNDERTAKER Everle Keyes & Co ADDRESS 1108 St. August

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, 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*, *Sar-*

coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)



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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH
County St. Louis
Township Central
or
Village
or
City

Registration District No. 790 File No.:
Primary Registration District No. 60330- Registered No. 97
(NO. St Vincent's Catholic St. Ward)

[[If death occurred in a hospital or institution, give its NAME instead of street and number]]

FULL NAME Fredonia W. Duckworth

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED DIVORCED OR WIDOWED MARRIED
(Write the word)

DATE OF BIRTH 4-18-868
(Month) (Day) (Year)

AGE 42 yrs 10 mos 2 ds. IF LESS than 1 day, ___ hrs or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work R.R. Agent
(b) General nature of industry, business, or establishment in which employed (or employer) S. B. R. [unclear]

BIRTHPLACE (City or town, State or foreign country) Ill. [unclear]

PARENTS
NAME OF FATHER Laron Duckworth
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill. [unclear]
MAIDEN NAME OF MOTHER Ely Brunen-
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill. [unclear]

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Duckworth
(ADDRESS) Presqueville Ill.

Filed 2/20 X 1911 X W. J. Egger REGISTRAR

Original file, date Apr 20 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2-20, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 2-14, 1911, to 2-20, 1911, that I last saw him alive on 2-20, 1911, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Congestion of Brain
one week

(Duration) ___ yrs ___ mos ___ ds.
Contributory Acute Malaria
(SECONDARY) (Duration) ___ yrs ___ mos ___ ds.
(Signed) H. W. Hermann M. D.
2-20 1911 (Address) 3634 Delmar Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs ___ mos ___ ds. In the State ___ yrs ___ mos ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL New Athens Ill. DATE OF BURIAL Feb 21 1911
UNDERTAKER Charles & Ray U. Co. ADDRESS 118 St. Angelo Ave

All information called for must be written on this Supplementary Certificate.

Vertical text on the left margin.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)