

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

PLACE OF DEATH

County

St Louis

Township

or

Village

or

City

University

Registration District No.

787

File No.

25880

Primary Registration District No.

4470

Registered No.

15

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

FULL NAME

James Harold Scheller

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OR RACE

White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

Single

DATE OF BIRTH

Jan 29th 1911
(Month) (Day) (Year)

AGE

6 yrs. *6* mos. *0* ds.

IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

D

BIRTHPLACE (City or town, State or foreign country)

St Louis

NAME OF FATHER

Unknown

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

Unknown

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nicholas Scheller

(ADDRESS)

Filed

7/31 1911 *Maurice Thompson*
REGISTRAR

DATE OF DEATH

July 30 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *July, 29-4 P.M., 1911*, to *July 30*, 1911, that I last saw her alive on *July, 30*, 1911, and that death occurred, on the date stated above, at *1 P.m.* The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory (SECONDARY)

1198
104
(Duration) *24* hours *0* mos. *0* ds.

(Signed)

W.E. Harrel M. D.

July 30, 1911 (Address) *6201 Etzel 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

Calvary

DATE OF BURIAL

July 31 1911

UNDERTAKER

Geo. N. Lynch

ADDRESS

4229 Olive

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. 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*, *Coal 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 septichaemia," "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.)



PLACE OF DEATH

County St. Louis

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

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

Township _____

Registration District No. 787

File No. _____

Village _____

Primary Registration District No. 4470Registered No. 15City University (NO. 900 N 63 St)

St. _____ Ward _____

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

FULL NAME James Harold Scheller

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(If write the word)DATE OF BIRTH Jan. 29, 1911
(Month) (Day) (Year)AGE 6 yrs. 6 mos. 6 ds. If LESS than 1 day, ____ hrs. or ____ min.?OCCUPATION (a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) St. LouisNAME OF FATHER UnknownBIRTHPLACE OF FATHER (City or town, State or foreign country) UnknownMAIDEN NAME OF MOTHER UnknownBIRTHPLACE OF MOTHER (City or town, State or foreign country) "

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nicholas Scheller(ADDRESS) 1900 N 63rd StFiled 7/31 1911, W. H. Simpson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 30, 1911
(Month) (Day) (Year)HEREBY CERTIFY, that I attended deceased from July 29-4 PM, 1911, to July 30, 1911, that I last saw her alive on July 30, 1911, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

Contributory (SECONDARY) _____

(Duration) 24 hours yrs. mos. ds.(Signed) W. E. Harral M. D.July 30, 1911 (Address) 6201 Etzel 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 CalvaryDATE OF BURIAL July 31, 1911UNDERTAKER Geo. H. Lynch ADDRESS 4229 OliveOriginal file, date 7/31, 1911

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

Revised United States Standard Certificate of Death

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

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