

PLACE OF DEATH

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

County _____

Township _____

or _____

Village _____

or _____

City St LouisRegistration District No. 701File No. 32608Primary Registration District No. 1008Registered No. 8057(NO. 422 N. 20 St)St. 17 Ward)

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

FULL NAME May Burgess

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OF RACE white SINGLE MARRIED single WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

May 7, 1911
(Month) (Day) (Year)

AGE

4 yrs. 23 mos. 23 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work ---(b) General nature of industry, business, or establishment in which employed (or employer) ---

BIRTHPLACE

(City or town, State or foreign country) St Louis

PARENTS

NAME OF FATHER

Benjamin BurgessBIRTHPLACE OF FATHER (City or town, State or foreign country) St Louis

MAIDEN NAME OF MOTHER

Edith A. BernathBIRTHPLACE OF MOTHER (City or town, State or foreign country) St Louis

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. C. Burgess(ADDRESS) 822 N. 23 St.Filed SEP - 7 1911Max C Starkloff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug 31, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Aug 30, 1911, to Aug 31, 1911, that I last saw her alive on Aug 31, 1911, and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

marasmus 34

Contributory

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. J. G. G.

M. D.

Aug 31, 1911 (Address) 815 N. Jefferson

*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

Cemetery

DATE OF BURIAL

Sept 1, 1911

UNDERTAKER

Harvey Mohr

ADDRESS

2614 Morgan

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.

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.)



County _____ Township _____ or _____ Village _____ or _____ City St Louis (NO. _____ St.: _____ Ward _____)

Registration District No. 791 File No. _____

Primary Registration District No. 603 Registered No. 8057

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

FULL NAME

May Burgess

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 5-7-1911
(Month) (Day) (Year)

AGE 4 yrs. 73 mos. 23 ds. If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

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

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

BIRTHPLACE

(City or town, State or foreign country) St Louis

PARENTS

NAME OF FATHER

Bryson Burgess

BIRTHPLACE OF FATHER

Springfield Mo

MAIDEN NAME OF MOTHER

Sarah Abernathy

BIRTHPLACE OF MOTHER

St Louis

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ble Burgess
(ADDRESS) 827 N. 23 St.

Filed Nov. 21 1911 A. G. Snodgrass
REGISTRAR

Original file date 9-1- 1911

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-31, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8-31, 1911, to 8-31, 1911, that I last saw her alive on 8-31, 1911, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

SyphilisW. G. Gannon M.D.

"/22/11 - 815 N. Jefferson Ave
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Lucas

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. O. Gannon M. D.
8-31, 1911 (Address) 815 N. Jefferson

*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

Cemetery

DATE OF BURIAL

9-1, 1911

UNDERTAKER

Harvey Shuler

ADDRESS

Harvey

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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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.)

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