

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

PLACE OF DEATH

County Schouie
Township Carroll
Village _____
City _____

Registration District No. 1123 File No. 24135
Primary Registration District No. 6248 C. Registered No. 284
(NO. Revere Barracks Rd. Ward)

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

FULL NAME Jacob S. Erb

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
DATE OF BIRTH <u>July 2</u> , 1894 (Month) (Day) (Year)		
AGE <u>18</u> yrs. — <u>11</u> mos. — <u>11</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm Hand</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-10-11</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>		
PARENTS	NAME OF FATHER <u>Charles Erb</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Mary Waldorf</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Missouri</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 13, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 28 — July 13, 1912,
that I last saw him alive on July 13, 1912,
and that death occurred, on the date stated above, at 11:5 m.
The CAUSE OF DEATH* was as follows:
Toxinetic Abscess 11:5 A
Sepsis
10 (Duration) yrs. mos. 15 ds.
Contributory (SECONDARY) Sepsis
(Duration) yrs. mos. 10 ds.
Signed Miss April M.D.
July 15 1912 (Address) Jeffers 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Erb
R. R. Off. Bks.
(ADDRESS) St Louis boundary
Filed JUL 15 1912 1912 L. Q. Chrost M. W.
REGISTRAR

PLACE OF BURIAL OR REMOVAL St Johns (Mehlville) DATE OF BURIAL July 16, 1912
UNDERTAKER Hoffmester & Co ADDRESS 7814 S. Bldg

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, Sarcoma*, 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.)

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

PLACE OF DEATH

County St. Louis

Township Carondelet

or

Village

or

City

Registration District No. 1123

File No. 24235

Primary Registration District No. 6248C

Registered No. 284

(NO. Rever's Barracks, Rd. Ward)

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

FULL NAME Jacob D. Erb

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF DEATH July 13, 1912
(Month) (Day) (Year)

DATE OF BIRTH July 2, 1894
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 28, 1912, to July 13, 1912
that I last saw him alive on July 13, 1912

AGE 18 yrs. 11 mos. 11 ds.
If LESS than 1 day, hrs. or mins.

that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

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

Tonsillar Abscess
(not tuberculous)
Sepsis Infectiva
(Duration) 13 yrs. 13 mos. 13 ds.

BIRTHPLACE (City or town, State or foreign country) Missouri

Contributory (SECONDARY) None
(Duration) 8 mos. 8 ds.

NAME OF FATHER Charles Erb

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

MAIDEN NAME OF MOTHER Mary Waldorf

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

Signed) St. J. Hill M. D.
July 15, 1912 (Address) Jeff. Bks. Mo.

*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 8 yrs. 8 mos. 8 ds. In the State 8 yrs. 8 mos. 8 ds.

Where was disease contracted If not at place of death?

Former or usual residence

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Erb

(ADDRESS) St. Louis County

PLACE OF BURIAL OR REMOVAL St. Johns (Mehlberg) DATE OF BURIAL July 16, 1912

SEP 7 1912

Filed 1912 L. O. Brock M.D. REGISTRAR

UNDERTAKER C. Hoffmeister ADDRESS 781 45. Bluff

Original file, date July 15, 1912 All information called for must be written on this Supplementary Certificate.

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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.)