

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.

PLACE OF DEATH

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

County _____

Township _____

or Village _____

or City St. Louis Mo. (NO. 208 S. 16 St St.; 6 Ward)

Registration District No. _____

Primary Registration District No. _____

File No. 7571

Registered No. 1927

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

FULL NAME Josie Williams

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE Colored SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH 2/25, 1913
(Month) (Day) (Year)

DATE OF BIRTH Unknown, 1871
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____ and that death occurred, on the date stated above, at 9-45-0 m.

AGE 42 yrs. 7 mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

THE CAUSE OF DEATH* was as follows:
Investigation pending
130
1200
(Duration) _____ yrs. _____ mos. _____ ds.

OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 9-10

BIRTHPLACE (City or town, State or foreign country) Mo.

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

NAME OF FATHER Gilbert Ballance

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

MAIDEN NAME OF MOTHER Jollie Inlaw

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

Signed H. W. Fath M.D. (Address) Deputy Comm
2/25, 1913

*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 208 S. 16th St.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Williams

(ADDRESS) 208 S. 16 Street

PLACE OF BURIAL OR REMOVAL Greenwood DATE OF BURIAL 2-26, 1913

UNDERTAKER Guffin & Co ADDRESS 2633 Market

Filed FEB 25 1913

REGISTRAR

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, peritonaeum*, 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.)

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.

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City St. Louis (NO. 208 S. 16th)

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 791 File No. _____
 Primary Registration District No. 1003 Registered No. 1927
 St. _____ Ward _____

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

FULL NAME Joie Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>Colored</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>unknown</u> 18 <u>71</u> (Month) (Day) (Year)		
AGE <u>42</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Mo. Mo.</u>		
PARENTS	NAME OF FATHER <u>Gilbert Wallace</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Waller Inlan</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 2/25 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h. found dead alive on _____, 191____, and that death occurred, on the date stated above, at 9.45 p.m.

The CAUSE OF DEATH* was as follows:
Acute gastro-enteritis

W.M.A.
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Acute Nephritis
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H.W. Gath M. D.
2/25 1913 (Address) Deputy Coroner

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Tom Williams
 (ADDRESS) 208 S. 16th St.

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 208 S. 16th St.

Filed 5-17 X 1913 A. G. Snodgrass REGISTRAR

PLACE OF BURIAL OR REMOVAL Greenwood DATE OF BURIAL 2-26 1913
 UNDERTAKER Buffint Scott ADDRESS 2633 Market

Revised United States Standard Certificate of Death

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

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