

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

PLACE OF DEATH

County St Louis
Township Carondelet
or
Village Koch Mo
or
City _____ (NO. Robt Koch Hospital St.: _____ Ward)

Registration District No. 1123 File No. 24103
Primary Registration District No. 6248B Registered No. 287

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

FULL NAME John Fraser

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Black SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF DEATH July 1, 1913
(Month) (Day) (Year)

DATE OF BIRTH August 8, 1889
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 22, 1913, to July 1st, 1913, that I last saw him alive on July 1st, 1913,

AGE 23 yrs. 10 mos. 24 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 5.40. The CAUSE OF DEATH* was as follows: A M

OCCUPATION (a) Trade, profession, or particular kind of work Laborer 3-07

Pulmonary Tuberculosis
23A
(Duration) 1 yrs. 8 mos. 8 ds.

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

BIRTHPLACE (City or town, State or foreign country) Coffeerville, Kas.

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

NAME OF FATHER Perry Fraser

(Signed) M. J. Surgen M. D.

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

July 1st, 1913 (Address) Koch, Mo

MAIDEN NAME OF MOTHER Tillie Fraser

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. 8 ds. In the 9 yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? St Louis, Mo

(Informant) Koch Hospital Records

Former or usual residence 1423 Morgan St St Louis, Mo

(ADDRESS) Koch, Mo.

PLACE OF BURIAL OR REMOVAL Anatomical Board DATE OF BURIAL July 9, 1913

UNDERTAKER Giggen Bros. ADDRESS St. Louis

Filed JUL 2 1913 L. P. Brock M.D. REGISTRAR
JUL 2 1913

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*, *Composer*, *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, for 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.)

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

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CERTIFICATE OF DEATH

PLACE OF DEATH 1

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

Registration District No. 1123 File No. _____
Primary Registration District No. 6248B Registered No. 287

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

FULL NAME John Fraser

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs _____ mos _____ 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) _____

PARENTS NAME OF FATHER _____ BIRTHPLACE OF FATHER (City or town, State or foreign country) _____ MAIDEN NAME OF MOTHER Mrs. Mauden Hault BIRTHPLACE OF MOTHER Georgia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. J. Records (ADDRESS) Koch Mo.

Filed Oct 14 1913 C. C. Brock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 1, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from _____ to _____, 1913, that I last saw him alive on _____, 1913,

and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: _____

(Duration) _____ yrs _____ mos _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs _____ mos _____ ds. (Signed) _____ M. D. _____, 1913 (Address) _____

*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 _____ usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1913 UNDERTAKER _____ ADDRESS _____

Supplementary Certificate

Revised United States Standard Certificate of Death

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

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