

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City _____

Registration District No. 791File No. 3184Primary Registration District No. 1000Registered No. 790City St Louis Mo. (NO. 2706 ^A Chouteau St. 15 Ward)

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

FULL NAME Tony Rubcic

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>Jan 4</u> , 18 <u>92</u> (Month) (Day) (Year)		
AGE <u>22</u> yrs. <u>—</u> mos. <u>16</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Laborer 23A
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 23B

BIRTHPLACE
(City or town, State or foreign country) AustriaNAME OF FATHER Tony RubcicBIRTHPLACE OF FATHER
(City or town, State or foreign country) AustriaMAIDEN NAME OF MOTHER UnknownBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Austria

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Rubcic(ADDRESS) 2706^A ChouteauFiled JAN 22 1914 1914 G. E. Snodgrass

DEPUTY REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 21st, 1914
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Jan. 20th, 1914, to Jan 21st, 1914, that I last saw him alive on Jan 21st, 1914, and that death occurred, on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:Pulmonary hemorrhage70 (Duration) 1 yrs. — mos. — ds.Contributory Pulmonary Tuberculosis
(SECONDARY)(Signed) Robert Bergloff M. D.
Jan 22nd, 1914 (Address) St. John's Hospital

*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. 2 ds. In the State 1 yrs. — mos. — ds.Where was disease contracted if not at place of death? 2706^A ChouteauFormer or present residence 2706^A ChouteauPLACE OF BURIAL OR REMOVAL St. Peter & Paul Cem. DATE OF BURIAL Jan 23, 1914UNDERTAKER E. J. Schmar ADDRESS 2652 Chouteau

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) *Colton 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.)

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____ Registration District No. 791 File No. _____
 or _____
 Village _____ Primary Registration District No. 1003 Registered No. 790
 or _____
 City St. Louis Mo. (NO. 2706 Chouteau St 15 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Stjepan Rubcic

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 4 1892
 (Month) (Day) (Year)

AGE 22 yrs. 16 mos. 16 ds. IF LESS than
 1 day, _____ hrs. _____ min.

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

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

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

NAME OF FATHER Toney Rubcic

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

MAIDEN NAME OF MOTHER Unknown

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Toney Rubcic(ADDRESS) 2706 A Chouteau

Filed _____ 1914 _____

REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 21st 1914
 (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 _____ m.

The CAUSE OF DEATH* was as follows:

Satisfactory Information Supplied.
 (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) _____ M. D.
 191____ (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 or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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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 "Asihenia," "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.)

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