

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 _____

Township _____

or

Village _____

or

City _____

Registration District No. 791

File No. 17592

Primary Registration District No. 1003

Registered No. 4785

City St. Louis (NO. 1637 Hagan St. 18 Ward)

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

FULL NAME John R. Exnicior

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH May 11th, 1914
(Month) (Day) (Year)

DATE OF BIRTH Jan 25, 1863
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 10th, 1914, to May 11th, 1914, that I last saw him alive on May 11th, 1914,

AGE 51 yrs. 3 mos. 17 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 8 P.m.

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

The CAUSE OF DEATH* was as follows:

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

Lobar Pneumonia
10.8 (Duration) 9 yrs. 3 mos. 3 ds.

BIRTHPLACE (City or town, State or foreign country) New Orleans

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

NAME OF FATHER Poland Exnicior

(Signed) James A. Dickson M. D. 1914 (Address) 1626 Biddle St

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

MAIDEN NAME OF MOTHER unknown

*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) New Orleans

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. ___ ds. in the State ___ yrs. ___ mos. ___ ds.

(Informant) Myrtle Exnicior

Where was disease contracted if not at place of death?

(ADDRESS) 1637 Hagan

Former or usual residence

Filed 1914 May 14 1914 10:15 AM St. Louis

PLACE OF BURIAL OR REMOVAL Calvary DATE OF BURIAL May 14, 1914

UNDERTAKER Mullen & Co. Colman ADDRESS 2402

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, 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, 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, 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.)

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

or
Village _____

City _____

Registration District No. 791

File No. 17592

Primary Registration District No. 1003

Registered No. 4785

(NO. _____)

St. _____

Ward _____

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

FULL NAME John D. X Exnicios X

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M

COLOR OR RACE W.

SINGLE MARRIED WIDOWED OR DIVORCED (If file the word) W.

DATE OF DEATH

May 11, 1914
(Month) (Day) (Year)

DATE OF BIRTH

(Month) _____ (Day) 1 (Year) _____

AGE

If LESS than 1 day, _____ hrs. or _____ min. _____ yrs. _____ mos.

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

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 Polard Exnicios

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

MAIDEN NAME OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Exnicios

(ADDRESS) 1637 Hogan St.

Filed OCT 13 1914

1914

REGISTRAR

Contributory (SECONDARY) _____

(Duration) _____ yrs. _____ ds.

(Signed) _____

_____ 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 residences _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 191____

UNDERTAKER: _____

ADDRESS _____

Original file, date _____ 19____

All information called for must be written on this Supplementary Certificate.

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Supplementary Information Supplied

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