

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

PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or  
Village \_\_\_\_\_

or  
City St Louis

Registration District No. 791

Primary Registration District No. 1003

File No. 24339

Registered No. 6761

(NO. 6005 a Suburban St. 27 Ward)

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

FULL NAME Minnie E Swofford

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

SEX Female COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH July 13, 1914  
(Month) (Day) (Year)

DATE OF BIRTH July 14, 1896  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from at June 15<sup>th</sup>, 1914, to July 13, 1914, that I last saw her alive on July 12<sup>th</sup>, 1914, and that death occurred, on the date stated above, at 10:30 p.m.

AGE 18 yrs. \_\_\_ mos. \_\_\_ ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
pneumonia  
10.5  
90.3  
(Duration) \_\_\_ yrs. \_\_\_ mos. 10 ds.

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

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

NAME OF FATHER Clinton Swofford

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

MAIDEN NAME OF MOTHER Ida M. Meyers

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

Contributory (SECONDARY) pneumonia  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) Orus H. Osterman M. D.  
July 14, 1914 (Address) 3148 Olive St

\*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) Mrs Ida M. Letinger  
(ADDRESS) 6005 a Suburban

PLACE OF BURIAL OR REMOVAL Calvary DATE OF BURIAL July 16, 1914

UNDERTAKER John C. Pensey, Sr ADDRESS 1136 N. 6th

Filed Jul 16 1914 1914 G. E. Snodgrass REGISTRAR

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, 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

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

County \_\_\_\_\_  
Township \_\_\_\_\_ or Village \_\_\_\_\_ or City St Louis  
Registration District No. \_\_\_\_\_ Primary Registration District No. 6005 Suburban File No. \_\_\_\_\_ Registered No. 6761  
(NO. 6005 Suburban St. 27 Ward)

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

FULL NAME Minnie E. Snofford

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH \_\_\_\_\_  
Date of birth (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 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 \_\_\_\_\_ BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_

Filed 12-17 1914 U. G. Brodgers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 13, 1914  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1914, to \_\_\_\_\_, 1914, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1914, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Pericarditis  
to. lobe pneumonia  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

Contributory pneumonia, lobe  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) C. W. Walker M. D.  
July 14, 1914 (Address) 3148 Olive

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. 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 \_\_\_\_\_ 1914  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY INFORMATION SUPPLIED

# Revised United States Standard Certificate of Death

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

24339

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