

## PLACE OF DEATH

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

County \_\_\_\_\_

Township \_\_\_\_\_

or  
Village \_\_\_\_\_or  
City St Louis (NO. 2909 N. Broadway St.: 2 Ward)Registration District No. 781Primary Registration District No. 1003File No. 24461Registered No. 6895

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

FULL NAME Edward Stenitzer

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OR RACE

WhiteSINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH

Oct 23, 1913  
(Month) (Day) (Year)

AGE

8 yrs. 8 mos. 26 ds.  
If LESS than  
1 day, \_\_\_ hrs.  
or \_\_\_ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work at home

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

BIRTHPLACE

(City or town, State or foreign country) St Louis

NAME OF FATHER

Ignatz Stenitzer

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Austria

MAIDEN NAME OF MOTHER

Maria Jng

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Austria

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ignatz Stenitzer(ADDRESS) 2909 N. BroadwayFiled JUN 19 1914 Max Starkloff REGISTRAR

DATE OF DEATH

July 18, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

July 16, 1914, to July 18, 1914,  
that I last saw him alive on July 15, 1914,and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH\* was as follows:

Marasmus2.5  
115  
158  
(Duration) yrs. mos. ds.Contributory Influenza  
(SECONDARY) (Duration) yrs. mos. ds.Signed G. F. Stimpfel M. D.  
7/19, 1914 (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 Galway DATE OF BURIAL July 20, 1914UNDERTAKER Edward Koch ADDRESS 3516 414th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S 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, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to indicate 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 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.)

## PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County \_\_\_\_\_  
 Township \_\_\_\_\_ Registration District No. 191 File No. \_\_\_\_\_  
 or \_\_\_\_\_  
 Village St Louis Primary Registration District No. 1003 Registered No. 6895-  
 or \_\_\_\_\_  
 City St Louis (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME

Eduard Stenitzer

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

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>Satisfactory Information Supplied.</u>		DATE OF DEATH <u>July 18</u> , 191 <u>4</u> (Month) (Day) (Year)
AGE _____ yrs. _____ mos. _____ ds.		HEREBY CERTIFY, that I attended deceased from <u>July 18</u> , 191 <u>4</u> , to _____, 191 <u>4</u> , that I last saw h. _____ alive on _____, 191 <u>4</u> , and that death occurred, on the date stated above, at _____ m.
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		The CAUSE OF DEATH* was as follows: <u>Acute Military Tubercu- losis of intestines</u>
BIRTHPLACE (City or town, State or foreign country) _____		Contributory <u>Asphyxia</u> (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
PARENTS	NAME OF FATHER _____	(Signed) <u>P. F. Stumpf</u> M. D. <u>7/19</u> , 191 <u>4</u> (Address) <u>3403 N. 14 st</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
	MAIDEN NAME OF MOTHER _____	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	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) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

FILE NO. 12-28 1914 A. G. Snodgrass REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_ 1914

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Original file, date JUL 1914

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

N. B.—Every item of information should be accurately supplied. Exact state. Part of OCCUPATION should state. Exact state. Part of OCCUPATION should state. Exact state. Part of OCCUPATION should state.

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