

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

PLACE OF DEATH

County _____

Township _____

Registration District No. 791

File No. 30328

Village _____

Primary Registration District No. 1002

Registered No. 8206

City St. Louis (NO. Mo. Pacific Hq. 15 Ward)

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

FULL NAME Thomas Wilson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug. 31, 1914
(Month) (Day) (Year)

DATE OF BIRTH Oct. 12, 1838
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 10, 1914 to Aug. 31, 1914, that I last saw him alive on Aug. 31, 1914, and that death occurred, on the date stated above, at 119 m.

AGE 75 yrs. 10 mos. 19 ds. If LESS than 1 day, ____ hrs. or ____ min.?

The CAUSE OF DEATH* was as follows:
Ascending Paralysis

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

BIRTHPLACE (City or town, State or foreign country) Mo.

(Duration) yrs. 6 mos. ds.

NAME OF FATHER Robert Wilson

Contributory (SECONDARY) general Debility
(Duration) yrs. 10 mos. ds.

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

(Signed) Ivan Judge M. D.
Aug. 31, 1914 (Address) St. Louis, Mo. Missouri Ac. Hosp.

MAIDEN NAME OF MOTHER Unknown

*Sign 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) Mo.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death - yrs. 3 mos. - ds. In the State 75 yrs. 10 mos. 19 ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Woodward

Where was disease contracted If not at place of death? 1129 Hodiamont
Former or usual residence 1129 Hodiamont

(ADDRESS) 1129 Hodiamont Ave

PLACE OF BURIAL OR REMOVAL Baldwin DATE OF BURIAL Sept 2, 1914

Filed SEP -1 1914 Max Starkloff REGISTRAR

UNDERTAKER Walter Helms ADDRESS 2331 10. Hwy

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, Compositor, 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.)

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

PLACE OF DEATH

County _____

Township _____ or _____

Village _____ or _____

City St. Louis NO. Mo Pacific Hosp St. 15 Ward _____

Registration District No. 791 File No. _____

Primary Registration District No. 1003 Registered No. 8206

FULL NAME Thomas Wilson

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W

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) _____

DATE OF DEATH Aug 31, 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:

Acute Myocardial Infarction

Contributory General debility, heart's (duration) _____ yrs. _____ mos. _____ ds. Chronic nephritis, sup. phase (duration) _____ yrs. _____ mos. _____ ds. by a Club at Mo Pacific Hosp (Address) _____

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

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) _____

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) _____

(ADDRESS) _____

Filed Sept 1 1914 H. G. G. Proctor REGISTRAR

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 1914

UNDERTAKER _____

ADDRESS _____

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30328
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