

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**

1 PLACE OF DEATH

County

Township

Village

City *St. Louis*

Registration District No. *V 791*

Primary Registration District No. *1003*

(No. *5921* *Kruphury* St. *28* Ward)

File No. *10686*

Registered No. *2547*

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

2 FULL NAME *Herbert Arnustead*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH *March 13, 1915*
(Month) (Day) (Year)

7 AGE *5* yrs. *5* mos. *5* ds. IF LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *None*
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) *St. Louis*

PARENTS 10 NAME OF FATHER *Herbert G. Arnustead*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Memphis Tenn*
12 MAIDEN NAME OF MOTHER *Burton James*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Mo.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *H. B. Arnustead*
(Address) *28 Kruphury Blvd.*

15 Filed *MAR 18 1915* *Max C. Starkloff*
1915 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 18, 1915*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *March 13, 1915* to *March 18, 1915*, that I last saw him alive on *March 17, 1915*, and that death occurred, on the date stated above, at *2 a.m.*

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
160B

(Duration)..... yrs. *15* mos. *15* ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs. mos. ds.
(Signed) *C. G. Wright* M. D.
3-18-1915 (Address) *6846 1/2 Clayton Ave.*

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL *St. Joseph Cemetery* DATE OF BURIAL *March 18, 1915*

20 UNDERTAKER *C. H. Taylor* ADDRESS *4449 Olive*

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) *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.)

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 _____

Registration District No. 791

File No. _____

Village _____

Primary Registration District No. 1003Registered No. 2547City St. Louis(NO. 5921 KensburySt. 28

Ward)

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

FULL NAME Herbert Armistead

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MCOLOR OR RACE WSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) SDATE OF DEATH Feb 18, 1915

(Month)

(Day)

(Year)

DATE OF BIRTH _____

(Month)

(Day)

(Year)

AGE _____

IF LESS than
1 day, ___ hrs
or ___ min
____ yrs. ____ mos. ____ ds.

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred, on the date stated above, at 20 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:

Cerebral Hemorrhage
From difficult labor
and forceps delivery

(Duration) _____

yrs.

mos.

ds. 5

BIRTHPLACE

(City or town, State or foreign country) _____

Contributory _____

(SECONDARY)

(Duration) _____

yrs.

mos.

ds. _____

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) _____

(Signed) C. G. Wright

M. D.

7181915(Address) 644 Chestnut

*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) _____

(ADDRESS) _____

Filed 3/181915Max C. Starkloff

REGISTRAR

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.

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.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

98901

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