

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

1 PLACE OF DEATH

County

Township
or
Village
or
City *St. Louis*

Registration District No. *701* File No. *10831*

Primary Registration District No. *1003* Registered No. *2701*

(No. *Mullaughy Hospital* St. *70* Ward)

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

2 FULL NAME *Mary B. Connell*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) *single*

6 DATE OF BIRTH *April 28* 18*96* (Month) (Day) (Year)

7 AGE *48* yrs. *10* mos. *23* ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS 10 NAME OF FATHER *Michael Connell* 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ireland* 12 MAIDEN NAME OF MOTHER *Ann M Kelly* 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ireland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *James R Connell* (Address) *3605 Page Boul*

15 Filed *MAR 23 1915* *A. S. Ginn & Co* Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 21* 191*5* (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Feb 18* 191*5* to *March 21* 191*5* that I last saw her alive on *March 22* 191*5* and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:
General Carcinoma
53E
52

(Duration) *3* yrs. *3* mos. *-* ds.

CONTRIBUTORY (Secondary) *None* (Duration) *-* yrs. *-* mos. *-* ds. (Signed) *P. J. Conner* M.D. *March 22 1915* (Address) *312 Humboldt*

*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 *1* yrs. *3* mos. *3* ds. In the State *1* yrs. *3* mos. *3* ds.

Where was disease contracted if not at place of death? Former or usual residence *3605 Page av*

19 PLACE OF BURIAL OR REMOVAL *babary* DATE OF BURIAL *3-24* 191*5*

20 UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 Wash et*

... fully supplied. ... so that it may be properly ...

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*, *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

County _____

Township _____

or _____

Village _____

or _____

City St. LouisMISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHREGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.Registration District No. 791

File No. _____

Primary Registration District No. 1003Registered No. 2701(NO. Mullaughy Hosp St. 20 Ward)(If death occurred in a
hospital or institution,
give its NAME instead
of street and number)FULL NAME Mary B. Cooney

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MCOLOR OR RACE WSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) SDATE OF DEATH Feb 21, 1915

(Month)

(Day)

(Year)

DATE OF BIRTH _____

(Month)

(Day)

(Year)

AGE _____

If LESS than
1 day, _____ hrs.
or _____ min.HEREBY CERTIFY, that I attended deceased from _____, 1915 to _____, 1915, that I last saw him _____, 1915, and that death occurred, on the date stated above, at _____ P. M.The CAUSE OF DEATH* was as follows:
General carcinoma of the
colon to determine it was found
to have been in the colon about
two or three years ago. The condition
system and the colon. (Duration) yrs. 3 mos. _____ ds.

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) _____

Contributory None

(SECONDARY)

(Duration) yrs. _____ mos. _____ ds.

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) _____

(Signed) Robert R. Hume3/22, 1915(Address) 312 Humboldt

M. D.

*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 St. Louis yrs. _____ mos. _____ ds. 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) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____ 1915Filed 3/23, 1915by Max B. Startloff

REGISTRAR

UNDERTAKER _____

ADDRESS _____

Original file, date _____ 1915

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

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state the plain terms of a disease, 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]

18831

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