

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. *28990*

Primary Registration District No. *1003*

Registered No. *668*

(NO. *2815 @ Charleston* St. *15* Ward)

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

2 FULL NAME *Robert Wesley Turner*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX *Male* 4 COLOR OR RACE *colored* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Married*  
(Write the date)

16 DATE OF DEATH *Sept 9th* 191*5*  
(Month) (Day) (Year)

6 DATE OF BIRTH *unknown* 1853  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Aug 27<sup>th</sup>* 191*5*, to *Sept 5<sup>th</sup>* 191*5*

7 AGE *60* yrs. mos. ds. If LESS than 1 day.....hrs. or.....min.?

that I last saw him alive on *Sept 5<sup>th</sup>* 191*5* and that death occurred, on the date stated above, at *7<sup>th</sup>* m.

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

The CAUSE OF DEATH\* was as follows:  
*Pericarditis*

9 BIRTHPLACE (City or town, State or foreign country) *Texas*

(Duration).....yrs. *4* mos. ds.

10 NAME OF FATHER *Robert Turner*

CONTRIBUTORY (Secondary) *St. Phillips*  
(Duration).....yrs. mos. ds.

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Texas*

(Signed) *W. C. Gordon* M. D.  
*89-10* 191*5* (Address) *11827 Cass St*

12 MAIDEN NAME OF MOTHER *Caroline Collins*

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

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Texas*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Jane Turner* (Address) *2815 Chestnut*

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.....

15 Filed.....191*5* *Mar E Starkloff* Registered

19 PLACE OF BURIAL OR REMOVAL *New Bethelham* DATE OF BURIAL *Sept 10* 191*5*  
20 UNDERTAKER *W. C. Gordon* ADDRESS *2649 Morgan*

# 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 "Asthma," "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.)

MISSOURI STATE BOARD OF HEALTH

1 PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County .....

Township or Village of St. Louis

Registration District No. 191

File No. ....

City St. Louis

Primary Registration District No. 1003

Registered No. 1668

(NO. .... St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Robert Wesley Turner

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE B 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) M.

16 DATE OF DEATH Sept. 9 1915  
(Month) (Day) (Year)

6 DATE OF BIRTH (Month) (Day) (Year) 1 1 191

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191

7 AGE If LESS than 1 day, .... hrs. or .... min. .... yrs. .... mos. .... ds.

that I last saw him alive on 191 and that death occurred, on the date stated above, at 191 m.

8 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: Pericarditis (acute)

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

(Duration) .... yrs. .... mos. .... ds. 77

10 NAME OF FATHER

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.

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

(Signed) G. R. Robinson M. D. 9-10 1915 (Address) 1827 Cass Ave.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (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.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

(Informant)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

(Address)

Where was disease contracted, if not at place of death?

Former or usual residence

15

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Filed NOV 20 1915 Wm. Starkloff Registrar

20 UNDERTAKER ADDRESS

1. Should state in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.

SUPPLEMENTARY INFORMATION SUPPLIED

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*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), *29ds.*; *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.)

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