

1 PLACE OF DEATH

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

County

Township

or

Village

or

City *Spokane* (NO. *10892*)Registration District No. *191*File No. *39356*Primary Registration District No. *1003*Registered No. *10666*(NO. *City Hospital*)St. *W* Ward2 FULL NAME *Jane Eastman*

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 SINGLE
MARRIED
OR DIVORCED
(Write the word)*Single*

6 DATE OF BIRTH

April 8, 1881
(Month) (Day) (Year)

7 AGE

35 yrs. *7* mos. *10* ds.If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

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

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

9 BIRTHPLACE

(City or town, State or foreign country)

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed *Nov 28 1916*

191

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 18, 1916
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from *Nov 11, 1916*, to *Nov 18, 1916*,that I last saw him alive on *Nov 17, 1916*,and that death occurred, on the date stated above, at *11:00 a.m.*

The CAUSE OF DEATH* was as follows:

Malaria 131
Chronic Interstitial Nephritis 38
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY
(Secondary)*120*
(Duration)..... yrs..... mos..... ds.(Signed) *B. W. Kessler* M. D.*Nov 18, 1916* (Address) *City Hospital*

*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. *7* ds. In the State..... yrs. *14* mos..... ds.

Where was disease contracted if not at place of death?

Former or usual residence *6237 McPherson*

19 PLACE OF BURIAL OR REMOVAL

Washington

DATE OF BURIAL

Nov 28, 1916

20 UNDERTAKER

Greger Bros

ADDRESS

17 E. 1st

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*, *Composer*, *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, 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 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.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state AGE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 PLACE OF DEATH

County
 Township
 or
 Village
 or
 City *Haus*

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

Registration District No. *791* File No.
 Primary Registration District No. *1003* Registered No. *10666*
 (NO. *City Hosp* St. *28* Ward).

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

2 FULL NAME *Sau Ehtuan*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*
 4 COLOR OR RACE *White*
 5 SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) *S -*
 6 DATE OF BIRTH (Month) (Day) 1. (Year)
 7 AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE
 City or town, State or foreign country
 10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov - 18* 191*6*
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, that I attended deceased from 191....., to 191....., that I last saw h..... alive on 191....., and that death occurred, on the date stated above, at m.
 The CAUSE OF DEATH* was as follows:

 (Duration) yrs. mos. ds.
 CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) M. D.
 191..... (Address)
 *State the Disease Causing Death, or, in deaths 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

SUPPLEMENTARY Information supplied

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant)
 (Address)
 15 Filed *Nov 22* 191*6* *Marb Starkoff*
 Registrar

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....
 20 UNDERTAKER ADDRESS

Original file, date *Nov 22*, 191*6*

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

Revised United States Standard Certificate of Death

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

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39358
Tuberculosis of lungs, meninges, peritonæum, 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 inter-current) 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 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.)