

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

1 PLACE OF DEATH

County
Township
or
Village
or
City *St. Louis* (NO. *Barnes Hospital* St. *3* Ward)

Registration District No. *721*
Primary Registration District No. *1002*

File No. *39724*
Registered No. *11055*

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

2 FULL NAME *Charles F. Grote*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH *July 7 1857*
(Month) (Day) (Year)

7 AGE *60* yrs. *10* mos. *10* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Watchman* (b) General nature of industry business, or establishment in which employed (or employer) *96*

9 BIRTHPLACE (City or town, State or foreign country) *Camden Ill 97*

PARENTS
10 NAME OF FATHER *William C Grote*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Germany*
12 MAIDEN NAME OF MOTHER *Augusta Schaeffer*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *C. F. Grote* (Address) *3654 Pennsylvania St*

15 Filed *NOV 20 1917* *Max C. Starloff* Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 17 1917*
(Month) (Day) (Year)

17 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 *5:15* m.

The CAUSE OF DEATH* was as follows:
Rupture of Aneurysm of the Aorta
W.M.A.

(Duration) yrs. mos. ds.
CONTRIBUTORY *Aneurysm & Arteriosclerosis*
(Secondary)
(Signed) *Tom Devor M.D.*
1119 1917 (Address) *Dep. Coroner*

*State the Disease Causing Death, or, in cases 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 st. yrs. mos. ds.
Where was disease contracted if not at place of death? *1200 Madison St*
Former or usual residence *1200 Madison St*

19 PLACE OF BURIAL OR REMOVAL *Valhalla Cem.* DATE OF BURIAL *11/20 1917*
20 UNDERTAKER *Bergesch Und Co 3661 Washington* ADDRESS *Ar*

PHYSICIANS should state OCCUPATION is very important. N. B.—Every item of information should be stated in plain terms. CAUSE OF DEATH

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, peritonacum*, 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 septicæmia," "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

1 PLACE OF DEATH

County
 Township or Village
 City *Mauis* (No. *Barnes Hosp. St.* St. *3* Ward) File No.
 Registration District No. *791* Registered No. *11055*
 Primary Registration District No. *1003*

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

2 FULL NAME

Charles F. Grote

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE
 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

PARENTS
 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 *9 1913* *Mauis Stark Off.*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov - 17* 191.....
 (Month) (Day) (Year)

17 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..... m.

The CAUSE OF DEATH* was as follows:
Display of aneurysm of the aorta
no surgery
aneurysm + aortic sclerosis
 CONTRIBUTORY (Secondary)
 (Duration)..... yrs..... mos..... ds.

(Signed) *H. H. Hath* M. D.
12/20, 1913 (Address) *Deputy County*

*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.....
 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191.....

20 UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Occupation is very important. Be sure that it may be properly clear. Do not state "ill" or "died" without giving the exact date.

SUPPLEMENTARY INFORMATION
 Satisfactory Information Supplied

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

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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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