

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County

Township

or

Village

or

City

Registration District No. 791

File No. 24874

Primary Registration District No. 1003

Registered No. 6511

(NO. 5633 Julian St. W. Ward)

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

2 FULL NAME

Alice L Crosby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE MARRIED *married* WIDOWED OR DIVORCED (Write the word)6 DATE OF BIRTH *March 4 1846*
(Month) (Day) (Year)7 AGE *72 yrs 3 mos 28 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) *Lyons N.Y.*10 NAME OF FATHER *Henry Belding*11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *N.Y.*12 MAIDEN NAME OF MOTHER *Lavinia Not known*13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *N.Y.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Eugenia Porter*(Address) *5633 Julian Ave*15 Filed *LL - 2 1918* *Mar 6 Startoff*

1918 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 2 1918*
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from *June 18th 1918* to *July 1st 1918*, that I last saw her alive on *July 1st 1918*, and that death occurred, on the date stated above, at *10:52 P.M.*

The CAUSE OF DEATH* was as follows:

*Arterio Sclerosis**92h**99*(Duration) *10 yrs 91 ds*CONTRIBUTORY (Secondary) *Heart lesion**metabol* (Duration) *15 yrs mos ds*(Signed) *W. H. Stauffer* M. D.*July 2, 1918* (Address) *537 W. Bank*

*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 *Missouri Crematory*DATE OF BURIAL *July 4 1918*20 UNDERTAKER *Chas Lupton*ADDRESS *444 9 Olive St*

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, 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 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.)

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CERTIFICATE OF DEATH

County

Township

Registration District No. 791

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Village

Primary Registration District No. 1003

Registered No. 6511

City: WEST LOUIS MO

(NO. 5633 Julian Avenue

St. Ward)

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

2 FULL NAME Alice Louise Crosby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow6 DATE OF BIRTH March 4th 1846
(Month) (Day) (Year)7 AGE 72 yrs. 3 mos. 28 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 Lyons, New York
(City or town, State or foreign country)PARENTS
10 NAME OF FATHER Silas Wells Belding
11 BIRTHPLACE OF FATHER Niagara Co., New York, (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER Lavina Hall Clarke
13 BIRTHPLACE OF MOTHER Lyons, New York. (City or town, State or foreign country)14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *S. W. Belding*
(Address) Webster Groves, Mo15 Filed July 2nd, 1918.
May C Starkloff
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2nd, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 18, 1918 to July 1st, 1918, that I last saw her alive on July 1st, 1918, and that death occurred, on the date stated above, at 10:55 P.M.

The CAUSE OF DEATH* was as follows:

Anterior Sclerosis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY Heart Lesion
(Secondary)

(Duration) 15 yrs. mos. ds.

(Signed) H. H. Stauffer M. D.

July 2nd 1918. (Address) 537 N. Grand

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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

Revised United States Standard Certificate of Death

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

24874

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"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.)