

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

14990

**1. PLACE OF DEATH**

County..... Registration District No. 891 File No. ....  
 Township St Louis Mo Primary Registration District No. 3100P Registered No. 3638  
 City St Louis Mo (No. 1502 & 102 str. .... St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St., 3 Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18-1858

7. AGE YEARS MONTHS DAYS U LESS than 1 day, hrs. or min.  
74 3 18

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work housework  
 (b) General nature of industry, business, or establishment in which employed (or employer).  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Indiana  
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER John McComack  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER not known  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known  
 (STATE OR COUNTRY)

14. INFORMANT Mrs Charles Maloy  
 (Address) 2508 Herbert str

15. FILED max B Starkoff  
 REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 6 19 23

17. I HEREBY CERTIFY, That I attended deceased from April 2, 1923, to April 6, 1923 that I last saw him alive on April 6, 1923 and that death occurred, on the date stated above, at 4:30 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Erysipelas  
15 d  
130  
194 B (duration) yrs. mos. 5 ds.  
 CONTRIBUTOR Nephritis Acute  
 (SECONDARY) (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Urinalysis

(Signed) A E Holdersold, M. D.

April 7, 1923 (Address) 4504 Virginia

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olive Country DATE OF BURIAL 4/8 19 23

20. UNDERTAKER Louis Spellbrink 1321 Franklin  
 ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, 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.)

**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 *Nona.*

**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 neoplasma); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

## 1 PLACE OF DEATH

County St. Louis

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City St. Louis (No. \_\_\_\_\_)DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

## STANDARD CERTIFICATE OF DEATH

3638

State of \_\_\_\_\_

Registered No. \_\_\_\_\_

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]2 FULL NAME Mrs Alice

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid  
(Write the word)6 DATE OF BIRTH Dec 18, 1858  
(Month) (Day) (Year)7 AGE 74 yrs. 3 mos. 18 ds. If LESS than 1 day, --- hrs. or --- min. 7

## 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 (State or country) \_\_\_\_\_

## 10 NAME OF FATHER \_\_\_\_\_

## 11 BIRTHPLACE OF FATHER (State or country) \_\_\_\_\_

## 12 MAIDEN NAME OF MOTHER \_\_\_\_\_

## 13 BIRTHPLACE OF MOTHER (State or country) \_\_\_\_\_

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15

Filed JUN 14 1923  
May 6 Starkeoff

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 6, 1923  
(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:

Corysipelias have caused  
loose patch of finger nail below toe.  
Information given over phone by  
Dr. W. E. Holdewell 6-14-23. out of St. L.  
(Duration) yrs. mos. ds.

Contributory (SECONDARY) \_\_\_\_\_

(Duration) 31 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 \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

## 20 UNDERTAKER

## ADDRESS \_\_\_\_\_

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