

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

1. PLACE OF DEATH

County..... Registration District No. 882 File No. 14105
 Township..... Primary Registration District No. 1000 Registered No. 3655
 City St. Louis (No. 5601^a) Lebanon Ave St. _____ Ward _____

2. FULL NAME Mrs Mary-Bell Gordon
 (a) Residence. No. 5601^a Calhoun St. 9 Ward. _____
 (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 12 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 Widow of Rev & C. Gordon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/21/1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 4 17

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Goshen
 (STATE OR COUNTRY) Rockbridge Co Va

10. NAME OF FATHER James Franklin Bell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Goshen
 (STATE OR COUNTRY) Rockbridge Co. Va

12. MAIDEN NAME OF MOTHER Elizabeth McDaniel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Goshen
 (STATE OR COUNTRY)

14. INFORMANT James G. McConkey
 (Address) Southern 5367 Maple av

15. FILED May 6 1923 May 6 1923
 REGISTER

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8th 1923

17. I HEREBY CERTIFY, That I attended deceased from June 2nd 1922, to April 8th 1923
 that I last saw her alive on April 5th 1923, and that death occurred, on the date stated above, at 3:15 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:**
Arteriosclerotic Nephritis
131
820
97 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hemiplegia, Atherosclerosis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) C. D. Bassett, M. D.
2479, 1923 (Address) 4500 Olive St

*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 Bellefontaine **DATE OF BURIAL** 4/10/23 19

20. UNDERTAKER M. Alexander **ADDRESS** 2835 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, 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, 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. _____)

St. _____

Ward _____)

2 FULL NAME

Mrs. Mary Bell Garden
561 1/2 CabanyDEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

Registered No. _____

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed6 DATE OF BIRTH Nov 21, 1887
(Month) (Day) (Year)7 AGE 73 yrs. 4 mos. 17 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work None

(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 191 Max B. Starkeoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8, 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:

Interstitial nephritis
Chronic. Information given over
Phone by Dr. G. W. Casper 6-24-23
Dir. of H. S.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____, M. D.

_____, 191_____ (Address) _____

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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 _____

50171

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