

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

14122

1. PLACE OF DEATH

County..... Registration District No. 892
 Township..... Primary Registration District No. 110000
 City St. Louis (No. 2612 N 20)
 Registered No. 3672
 St. Ward)

2. FULL NAME

Mary Frances Stahl
 (a) Residence. No. 2612 N 20 St., 5 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) August - 1856
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 7 3
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Indiana

10. NAME OF FATHER

Peter Eder

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

14.

INFORMANT W. L. Stahl
 (Address) 2612 N. 20th St.

15.

FILED W. L. Starrkopf
 REGISTERED

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1923
 17. I HEREBY CERTIFY That I attended deceased from April 2 1923 to April 8th 1923 that I last saw h. alive on April 8th 1923 and that death occurred, on the date stated above, at 11:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia tuberculosa
23A
162

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. L. Stahl, M. D.

April 9, 1923 (Address) 4000 E. Polk

*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

balcony

DATE OF BURIAL

April 11 1923

20. UNDERTAKER

August Bronckland & Co. 1421. 189

N. B.—Every item of information should be carefully supplied. AGE shown 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 *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 _____

Village _____

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

STANDARD CERTIFICATE OF DEATH

State of _____ Registered No. _____

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

2 FULL NAME Mary Frances Stahl

St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH Aug 4 1895

(Month) (Day) (Year)

7 AGE 66 yrs. 7 mos. 3 ds. 1 day, 1 hr. 0 min. 0 sec.

IF LESS THAN 1 day, hr. min. sec.

8 OCCUPATION Housewife

(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 1911 Max B Starkoff

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:

Pneumonia Tuberculosis
Chronic Infection given
Phone by Dr. Chas. H. Bang
6-14-23, Div. of W. S.
(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 _____ In the _____ yrs. _____ mos. _____ ds. 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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[Approved by U. S. Census and American Public Health Association]

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