

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

1. PLACE OF DEATH

County..... Registration District No. 791 File No.
Township..... Primary Registration District No. 1003 Registered No. F 890
City St Louis (No. Peoples Hospital) St. Ward)

2. FULL NAME

Annie Sparks
(a) Residence, No. Carroll Island St., 71 Ward. Union Hill
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Orin Sparks
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1900
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
28 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

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

10. NAME OF FATHER John Robbins
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss
12. MAIDEN NAME OF MOTHER Sally Copeland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Miss

14. INFORMANT Orin Sparks (Address) Union Hill

15. FILED 31 1928 Mar 6 Starloff Registrar

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 4, 1928, to Jan 24, 1928 that I last saw her alive on Jan 23, 1928, and that death occurred, on the date stated above, at 10911 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bleeds pneumonia
35 hr
139 hr
109 hr
(duration) 6 yrs. 6 mo. 6 ds.

CONTRIBUTORY (SECONDARY) Hysterectomy - Bilateral Solpangitomy (duration) 1 yrs. 1 mo. 1 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH... Home
19. DID AN OPERATION PRECEDE DEATH... Yes DATE OF Jan 4 - 1928
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS (Signed) D. Keale Wilson, M. D. , 19 (Address) Union Hill

*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 Union Hill DATE OF BURIAL Jan 24 1928

20. UNDERTAKER J. Marshall ADDRESS Union Hill

WRITE P
N. B.—Every item of information shown as furnished should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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 employ-
ment, it is necessary to know (a) the kind of work (b) the nature of the business or industry, for an additional line is provided for the statement; it should be used only when needed. Examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Sales-Grocery*, (a) *Foreman*, (b) *Automobile factory*; material worked on may form part of the statement. Never return "Laborer," "Fore-Manager," "Dealer," etc., without more specification, as *Day laborer, Farm laborer, Coal mine*, etc. Women at home, who are not performing the duties of the household only (not paid servants who receive a definite salary), may be designated as *Housewife, Housework* or *At home*, and not gainfully employed, as *At school* or *At work*. 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City..... (No.)

Registration District No. 791
Primary Registration District No.
Pepper Vasep

File No.
Registered No. 870
St. Ward

2. FULL NAME Annig Sparks

(a) Residence. No. St. Ward. Marion, Ill.
(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 A 4. COLOR OR RACE B. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED M.V. -9 1927 Marb Starloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h. here on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bilateral Pneumonia
1000
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hysterectomy Bilateral

Salpingitis non Purulent. Unconscious Information given over phone by Dr. Williams

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. Rev. of U.S. 4-12-25

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. SUPPLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. What attachment of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-3264