

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. City Hospital)

File No. 21943
Registered No. 5802
St. Ward)

2. FULL NAME

(a) Residence, No. 4471 Olive Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>John M. Schneider</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jun 18, 1884</u>		
7. AGE	YEARS <u>49</u>	MONTHS <u>6</u>
	DAYS <u>12</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Home</u>	
	10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/30 19 33

22. I HEREBY CERTIFY, That I attended deceased from 5/16 19 33, to 6/30 19 33

I last saw her alive on 6/30 19 33 Death is said to have occurred on the date stated above, at 2:10 P.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhages (multiple) Date of onset 5-16-33

82A

107A

Other contributory causes of importance: 82A

Bronchial Pneumonia 6-25-33

MOTHER FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Louis, Missouri</u>
	13. NAME <u>Frank Weselsky</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bohemia</u>
	15. MAIDEN NAME <u>Mary Nemecsek</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bohemia</u>

17. INFORMANT HOSPITAL FREEMOTION
(ADDRESS) MIDDLEBENT CITY HOSPITAL

18. BURIAL, CREMATION, OR REMOVAL
PLACE Valhalla DATE July 3 33

19. UNDERTAKER Mr. E. Maxwell
(ADDRESS) Allen

20. FILED JUL - 5 1933
J. F. Bredek
Registrar.

Name of operation..... Date of.....

What test confirmed diagnosis? clinical Was there an autopsy? No

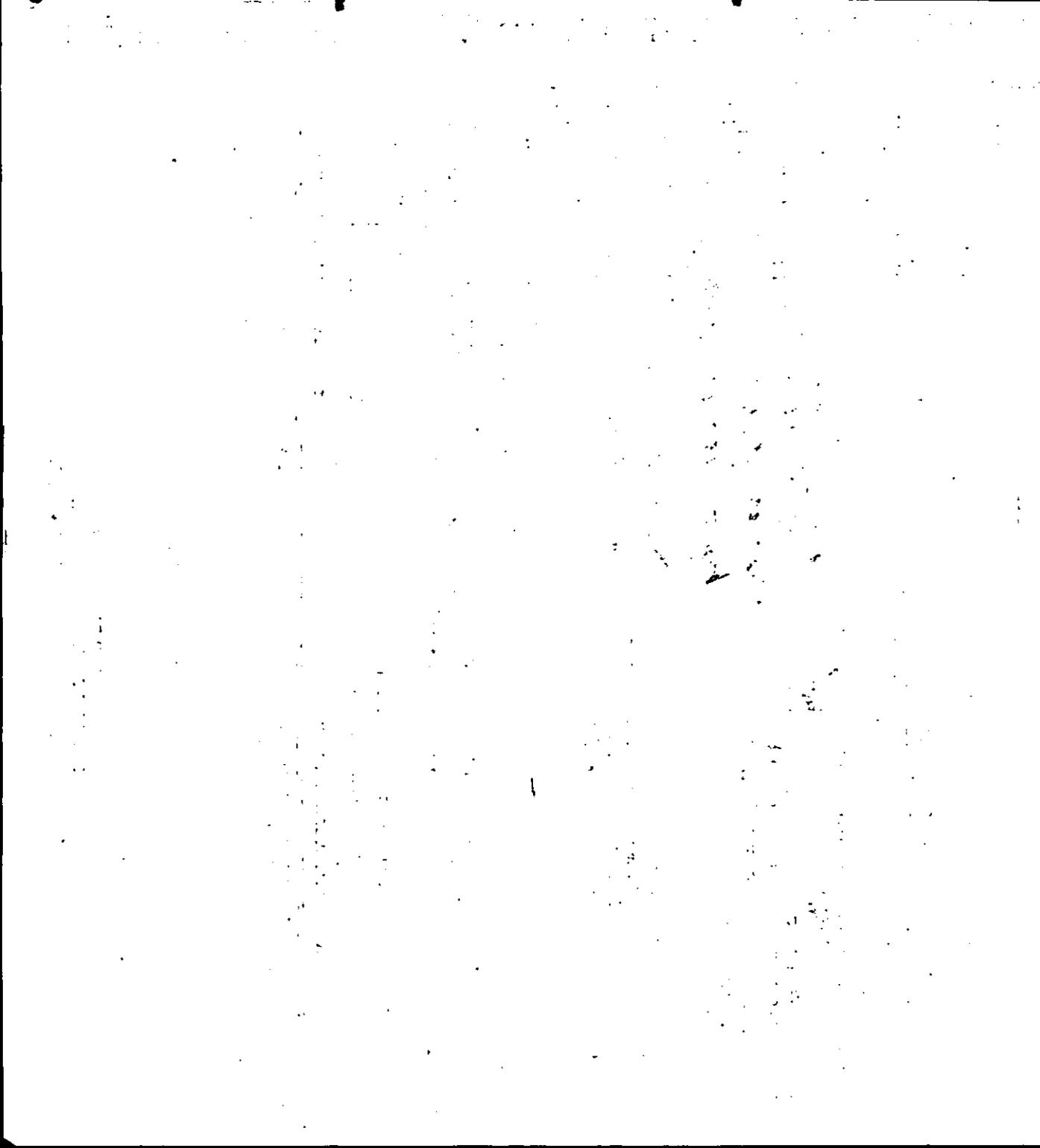
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Arthur G. Hines, M. D.
(Address) City Hospital

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.

2550
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH.

County..... Registration District No. 721
 Township..... Primary Registration District No. 503
 City..... (No. City Hosp.)..... St. Ward)

File No.
 Registered No. 5802

2. FULL NAME

Mary Catherine Schneider

(a) Residence. No. 4471 Olive St., 19 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 F. 4. COLOR OR RACE H. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 18-1885

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	<u>48</u>	<u>6</u>	<u>12</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Stenog.
 (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) St. Louis, Mo.

10. NAME OF FATHER Frank H. Plesky

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

12. MAIDEN NAME OF MOTHER Emily Nemerek

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

14. INFORMANT (Address) Mildred Kent City Hosp

15. July 4 1933 J. J. Breddeck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/30 1933

17. I HEREBY CERTIFY That I attended deceased from 5/16 1933 to 6/30 1933
 that I last saw him/her alive on 6/30 1933, and that death occurred, on the date stated above, at 2:10 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage (multiple)
 (duration) yrs. mos. ds.
 CONTRIBUTORY Bronchial Pneumonia
 (SECONDARY) (duration) yrs. mos. ds.

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) Arthur G. Hanes, M. D.
 , 19 (Address) City Hospital

*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 DATE OF BURIAL
Valhalla July 3 1933

20. UNDERTAKER ADDRESS
W. L. Mayall 1936 Alley

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

5-21943
"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 neoplasm); *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.