

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

Do not use this space.

7256

APR 25 1934

**1. PLACE OF DEATH**

County .....  
Township .....  
City St. Louis (No. City Hospital)

Registration District No. 791  
Primary Registration District No. 1003

File No. ....  
Registered No. 2142  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. 3117 1/2 Washington Ward. 21  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 23-1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 3 5

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

13. NAME Whitaker, Mayson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Sarah Kelly

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Wm. J. Kelly

18. BURIAL, CREMATION, OR REMOVAL PLACE Jefferson Barracks DATE Mar 3 1934

19. UNDERTAKER (ADDRESS) Arthur J. Donnelly, 21 So. 3840 Grand St.

20. FILED 102 1934 J. H. Brebeck Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/28 1934

22. I HEREBY CERTIFY, That I attended deceased from 2/10 1934, to 2/28 1934

I last saw him alive on 2/28 1934. Death is said to have occurred on the date stated above, at 10:15 a.m.

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

Abscess of Spleen  
Caused by pneumonia  
734  
125

Other contributory causes of importance:

General Peritonitis

Name of operation Laparotomy date of .....

What test confirmed diagnosis? ..... Was there an autopsy? yes

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) J. H. Brebeck, 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.

PHYSICIAN'S STATEMENT OF OPINION  
The patient should be treated EXACTLY as directed by the physician.  
The patient should be treated EXACTLY as directed by the physician.  
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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**1. PLACE OF DEATH.**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... Registered No. 2142  
 City..... (No. City Loop)..... St. .... Ward.....

18866  
**2. FULL NAME** Wayson Whitaker

(a) Residence. No. 3117<sup>2</sup> Washington 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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-28-1934

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

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Abscess of spleen (see histological)

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

CONTRIBUTORY (SECONDARY) general peritonitis ruptured spleen abscess

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 .....

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

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

DID AN OPERATION PRECEDE DEATH? yes, laparotomy  
 WAS THERE AN AUTOPSY? yes  
 WHAT TEST CONFIRMED DIAGNOSIS? Laparotomy and Autopsy  
 (Signed) J. G. Bauer, M. D.  
 , 19 (Address) City Loop

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) .....

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

15. FILED ..... 19.....  
Mar 2, 1934  
J. Bredeck  
 REGISTRAR

20. UNDERTAKER ..... ADDRESS .....

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

SUPPLEMENTARY

# 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 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.

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