

PLACE OF DEATH

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

County _____

Township _____

or

Village _____

or

City St. Louis Mo. (NO Jewish Hosp. St. 28 Ward)Registration District No. 781

File No. _____

Primary Registration District No. 1003Registered No. 4243

14692

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

FULL NAME James Fabricius Keith

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White ~~SINGLE~~ MARRIED Married
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)DATE OF DEATH April 25, 1914
(Month) (Day) (Year)DATE OF BIRTH January 18th, 1849
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from March 30, 1914, to April 25, 1914
that I last saw him alive on April 24, 1914,
and that death occurred, on the date stated above, at 6⁴⁵ am.AGE 65 yrs. 3 mos. 7 ds. IF LESS than
1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION
(a) Trade, profession, or particular kind of work Physician59 Diabetes mellitus
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(b) General nature of industry, business, or establishment in which employed (or employer)

50
(Duration) 2 yrs. ___ mos. ___ ds.BIRTHPLACE
(City or town, State or foreign country) MissouriContributory Hypertrophied Prostate
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.NAME OF FATHER W. F. Keith(Signed) Sister Feholok M. D.
April 25, 1914 (Address) 453 N TaylorBIRTHPLACE OF FATHER
(City or town, State or foreign country) KentuckyMAIDEN NAME OF MOTHER Martha Jane Sampson

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Missouri

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death ___ yrs. ___ mos. 26 ds. In the State ___ yrs. ___ mos. ___ ds.(Informant) W. F. KeithWhere was disease contracted If not at place of death? at Surgeon(ADDRESS) Sturgeon Mo.Former or usual residence Sturgeon Mo.PLACE OF BURIAL OR REMOVAL Sturgeon Mo DATE OF BURIAL April 27, 1914Filed 27 1914 May 27 1914 May 27 1914UNDERTAKER W. Lupton ADDRESS 4449 Olive St

REGISTRAR

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 is 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, Compositor, 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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)