

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
County Calveras
Township St. Aubert
or Western
Village _____
or _____
City _____ (NO. _____) St. _____ Ward _____

Registration District No. 105 File No. 12451
Primary Registration District No. 4404 Registered No. 6
5154

FULL NAME not named Still Born

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH: <u>April</u> (Month) <u>6</u> (Day) <u>1910</u> (Year)		
AGE <u>Still Born</u>	IF LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>X</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Mokame Mo.</u>		
PARENTS	NAME OF FATHER <u>Henry Bloom</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Calveras</u>	
	MAIDEN NAME OF MOTHER <u>Stillborn</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 6 (Month) 6 (Day) 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from April 6, 1910, to April 6, 1910, that I last saw him alive on still born, 1910, and that death occurred, on the date stated above, at X m.

The CAUSE OF DEATH* was as follows:
Still Born
NO CODE

(Duration) ___ yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. [Signature]
(ADDRESS) [Signature]

Filed May 9, 1910, W. F. Williamson REGISTRAR

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) [Signature] M. D.
1910 (Address) Mokame

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted: if not at place of death? X

Former or usual residence.

PLACE OF BURIAL OR REMOVAL [Signature] DATE OF BURIAL Apr 6, 1910

UNDERTAKER L. G. [Signature] ADDRESS _____

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

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), *20 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

MISSOURI
BUR

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.....)
 Registration District No.
 Primary Registration District No.

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)..... / (Day)..... / (Year).....	
AGE yrs. mos. ds.	IF LESS than 1 day.....hrs. or.....min.?

OCCUPATION

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

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191.....

REGISTRAR

MEDICAL

DATE OF DEATH

I HEREBY

that I last saw h.....
 and that death occur.....
 The CAUSE OF DEATH

Contributory (secondary)

(Signed)

*State the Disease Cause (1) Means of Entry; and (2) w

LENGTH OF RESIDENCE RECENT RESIDENTS

At place of death..... yrs. mc
 Where was disease contracted if not at place of death?
 Former or usual residence.....

PLACE OF BURIAL OR

UNDERTAKER