

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

PLACE OF DEATH

County Jefferson
Township Road
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 423 File No. 31771
Primary Registration District No. 5578 Registered No. 41

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

FULL NAME William Swales

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH September 16, 1911
(Month) (Day) (Year)
AGE _____ yrs. _____ mos. 5 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) _____

DATE OF DEATH September 22, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 20, 1911, to Sept 22, 1911, that I last saw h Did not see body alive on _____, 1911, and that death occurred, on the date stated above, at 4 1/2 p.m.

The CAUSE OF DEATH* was as follows:
Convulsions, caused by acute indigestion, body owing to death of mother, being fed antiseptics
(Duration) _____ yrs. _____ mos. _____ ds. duration 2 days

BIRTHPLACE (City or town, State or foreign country) Road Creek, Mo.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. J. Kirk M. D.
09-23 1911 (Address) Unsubscribed

PARENTS
NAME OF FATHER Frank Swales
BIRTHPLACE OF FATHER (City or town, State or foreign country) Road Creek, Mo.
MAIDEN NAME OF MOTHER Annie Kadeetz
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Road Creek, Mo.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Swales
(ADDRESS) Valley Park, Mo.

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?
Former or usual residence _____

Filed 9-23 1911 M. J. Kirk
REGISTRAR

PLACE OF BURIAL OR REMOVAL Road Creek Cath. Cem DATE OF BURIAL 9-23 1911
UNDERTAKER J. L. Koch ADDRESS Fulton Mo

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.

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*, *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, peritoneum*, etc., *Carcinoma*, *Sar-*

coma, 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.)



PLACE OF DEATH

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

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CERTIFICATE OF DEATH

County Jefferson
Township Rock
or
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City _____ (NO. _____ St. _____ Ward)

Registration District No. 423 File No. _____
Primary Registration District No. 5578 Registered No. 41

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

FULL NAME Wm Swaller

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED Single
(# rite the word)
DATE OF BIRTH 9-16-1911
(Month) (Day) (Year)
AGE 5 yrs. 5 mos. 5 ds. IF LESS than 1 day, hrs. or min.

OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Rock Creek Mo.

PARENTS
NAME OF FATHER Wm Swaller
BIRTHPLACE OF FATHER (City or town, State or foreign country) Rock Creek
MAIDEN NAME OF MOTHER Kathleen
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rock Creek

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Swaller
(ADDRESS) Valley Park Mo.

Filed Sept 23 1911 by Prof. F. Kincaid REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 9-27, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 9/19/11, 1911, to 9/27/11, 1911, that I last saw h. alive on 9/27/11, 1911, and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH* was as follows:
Gastric enteritis

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W J Kirk M. D.
9-22, 1911 (Address) Wm Swaller

*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? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Rock Creek DATE OF BURIAL 9 27, 1911

UNDERTAKER J S Kirk ADDRESS Wm Swaller

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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