

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 Chariton
Township Keytesville Registration District No. 171 File No. 547
or
Village _____ Primary Registration District No. 8237 Registered No. 4
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Wm. C. Adams

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Married</u>	DATE OF DEATH <u>1</u> (Month) <u>14</u> (Day) <u>1912</u> (Year)	
DATE OF BIRTH <u>Oct</u> (Month) <u>15</u> (Day) <u>1876</u> (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Jan</u> , 19 <u>09</u> , to <u>Jan</u> , 19 <u>12</u> , that I last saw him alive on <u>Jan 13</u> , 19 <u>12</u> , and that death occurred, on the date stated above, at <u>3:30</u> A. M.	
AGE <u>45</u> yrs. <u>2</u> mos. <u>29</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Bright's disease</u> <u>Nephritis</u> <u>137A</u> (Duration) <u>two</u> yrs. ___ mos. ___ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-02</u>			Contributory <u>organic heart disease</u> (SECONDARY) <u>disease</u> (Duration) ___ yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Newbury</u>			(Signed) <u>A. W. Williams</u> M. D. <u>1-14</u> , 19 <u>12</u> (Address) <u>Brunswick</u>	
PARENTS	NAME OF FATHER <u>Geo Adams</u>		*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 FATHER (City or town, State or foreign country) <u>Virginia</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
	MAIDEN NAME OF MOTHER <u>Martin</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Newbury</u>		PLACE OF BURIAL OR REMOVAL <u>Keytesville</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) <u>W. B. Adams</u>			DATE OF BURIAL <u>1-15</u> , 19 <u>12</u>	
Filed <u>Jan 14</u> , 19 <u>12</u> <u>B. Hughes</u> REGISTRAR			UNDERTAKER <u>M. B. Smith</u> <u>Keytesville</u> ADDRESS _____ <u>770-</u>	

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, peritonaeum*, 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.)



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

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Chariton
Township Keytesville
or
Village
or
City _____ (NO. _____ St.; _____ Ward)

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

Registration District No. 171 File No. 547
Primary Registration District No. 3237 Registered No. 4

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

FULL NAME Wm C Adams

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)
DATE OF BIRTH Oct 15 1886
(Month) (Day) (Year)
AGE 75 yrs 2 mos 29 ds. If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Kentucky

PARENTS
NAME OF FATHER Geo. Adams
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
MAIDEN NAME OF MOTHER Martin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Adams

(ADDRESS) Keytesville Mo

Filed Jan 15 1912 by W. B. Adams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 17 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 14, 1912, to Jan 17, 1912, that I last saw him alive on Jan 13, 1912, and that death occurred, on the date stated above, at 3:30 A.

The CAUSE OF DEATH* was as follows:
Cerebral poisoning with nitral insufficiency
(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) A. W. Gillman M. D.
Jan 15 1912 (Address) Brunswick

*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 Keytesville DATE OF BURIAL Jan 15 1912

UNDERTAKER W. B. Hunt ADDRESS Keytesville

* All information called for must be written on this Supplementary Certificate.

JAN

mo

Revised United States Standard Certificate of Death

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