

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

PLACE OF DEATH

County Scott

Township \_\_\_\_\_

or Village \_\_\_\_\_

or City Oran, Mo. (NO. \_\_\_\_\_)

Registration District No. 820

Primary Registration District No. ~~6089~~

File No. 57766

Registered No. 6

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME George Washington Speer

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Caucas. SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

DATE OF BIRTH July 3, 1866  
(Month) (Day) (Year)

AGE 45 yrs. 5 mos. 5 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) Indiana

PARENTS NAME OF FATHER Jacob Speer

BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana

MAIDEN NAME OF MOTHER Jane Fields

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Speer

(ADDRESS) Oran, Mo.

Filed 279 1912 R. G. Glenn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 25, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 15, 1911, to Nov. 25, 1911, that I last saw h. lm alive on Nov. 24, 1911, and that death occurred, on the date stated above, at X m. The CAUSE OF DEATH\* was as follows:

Pneumonia

Contributory none  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.

(Signed) H. S. Winters M. D.  
1911 (Address) Oran, Mo.

\*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 Oran, Mo DATE OF BURIAL 11 25 1911

UNDERTAKER J. S. Heisserer ADDRESS Oran, Mo

MARGIN RESERVED FOR BINDING

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.

# 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, 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.)



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PLACE OF DEATH

County Scott  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City Ocran Mo. (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

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

Registration District No. 820 File No. 7766  
 Primary Registration District No. 4496 Registered No. 6

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

FULL NAME George Washington Speer

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>m.</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>m.</u>	DATE OF DEATH <u>Nov. 25</u> , 191 <u>1</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>July 3</u> , 18 <u>66</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Nov. 25</u> , 191 <u>1</u> , to <u>Nov. 25</u> , 191 <u>1</u> , that I last saw h. <u>m.</u> alive on <u>Nov. 24</u> , 191 <u>1</u> , and that death occurred, on the date stated above, at <u>9:26</u> m.		
AGE <u>45</u> yrs. <u>5</u> mos. <u>5</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.	The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u>			(Duration) _____ yrs. _____ mos. <u>8</u> ds.		
(b) General nature of industry, business, or establishment in which employed (or employer)			Contributory <u>none</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>			(Signed) <u>H.S. Winters</u> M. D. <u>Feb 9, 1912</u> (Address) <u>Ocran Mo.</u>		
PARENTS	NAME OF FATHER <u>Jacob Speer</u>	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ind.</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	MAIDEN NAME OF MOTHER <u>Gene Fields</u>	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ind.</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas. Speer</u>			Where was disease contracted if not at place of death? Former or usual residence _____	
	(ADDRESS) <u>Ocran Mo.</u>			PLACE OF BURIAL OR REMOVAL <u>Ocran Mo.</u>	DATE OF BURIAL <u>11/26</u> , 191 <u>1</u>
Filed <u>79</u> , 191 <u>1</u>	REGISTRAR <u>R.C. Glass</u>		UNDERTAKER <u>J.S. Heissenet</u>	ADDRESS <u>Ocran Mo.</u>	

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