

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Linn Co</i>		Registration District No.	<i>42</i>	
Township	<i>Dexter</i>		Primary Registration District No.	<i>4274</i>	
or			St.	Ward	
Village			Registered No.	<i>9894</i>	
or			Registered No.	<i>19</i>	
City	<i>Higginsville</i>		[If death occurred in a hospital or institution, give its NAME instead of street and number]		
FULL NAME <i>Frank Whipple</i>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWER OR DIVORCED (Write the word)	DATE OF DEATH		
<i>male</i>	<i>White</i>	<i>Single</i>	<i>Mar. 18</i>		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
<i>July 20, 1889</i>			<i>Mar 18</i> , 191 <i>2</i> , to <i>Mar 18</i> , 191 <i>2</i>		
AGE			that I last saw h. <i>alive</i> on <i>3/18/12</i> at <i>8:30 P.M.</i> , 191 <i>2</i>		
<i>32</i> yrs. <i>7</i> mos. <i>16</i> ds.			and that death occurred, on the date stated above, at <i>11 P.M.</i>		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work <i>Carpenter Workman</i>			<i>Cerebro Spinal Meningitis</i>		
(b) General nature of industry, business, or establishment in which employed (or employer) <i>5-62</i>			<i>18</i>		
BIRTHPLACE (City or town, State or foreign country)			(Duration) _____ mos. _____ ds.		
<i>Wichita, Kansas</i>			Contributory <i>None</i>		
PARENTS	NAME OF FATHER		(SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
	<i>Ch. W. Whipple</i>		(Signed) <i>W. W. Muehlen</i> M. D.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		<i>3/19</i> , 191 <i>2</i> (Address) <i>Higginsville Mo</i>		
	<i>Perm</i>		*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		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
<i>Helen M. Coulon</i>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
BIRTHPLACE OF MOTHER (City or town, State or foreign country)		Where was disease contracted If not at place of death?			
<i>Brook Craig N. M.</i>		Former or usual residence _____			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <i>Mrs. Chas. Farrell</i>					
(ADDRESS) <i>Solomon Kansas</i>					
Filed <i>Mar 20</i> , 191 <i>2</i> <i>Chas W. Whipple</i> REGISTRAR					
PLACE OF BURIAL OR REMOVAL			DATE OF BURIAL		
<i>Wichita, Kan</i>			<i>Mar 21</i> , 191 <i>2</i>		
UNDERTAKER			ADDRESS		
<i>W. W. Muehlen</i>			<i>Higginsville Mo</i>		

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*, *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.)



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

PLACE OF DEATH
 County Lafayette
 Township _____
 or
 Village _____
 or
 City Higginsville (NO. _____) St. _____ Ward _____

Registration District No. 460 File No. _____
 Primary Registration District No. 4274 Registered No. 18

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

FULL NAME Frank Whipple

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED S (Write the word)
 DATE OF BIRTH July 20, 1889
 (Month) (Day) (Year)
 AGE 22 yrs. 7 mos. 18 ds. If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION (a) Trade, profession, or particular kind of work Carpenter
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 BIRTHPLACE (City or town, State or foreign country) Elsworth Kans

DATE OF DEATH Mar 18, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Mar 18, 1912, to Mar 18, 1912
 that I last saw him alive on Mar 18, 1912
 and that death occurred, on the date stated above, at 11 P. M.
 The CAUSE OF DEATH* was as follows:
Cerebro spinal meningitis epidemic.
 (Duration) _____ yrs. _____ mos. _____ ds.

PARENTS
 NAME OF FATHER F. M. Whipple
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Peru
 MAIDEN NAME OF MOTHER Helen M. Carlson
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) N. Mex

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. C. Brockman M. D.
May 8, 1912 (Address) Higginsville
 *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) Mrs. Chas Farrell
 (ADDRESS) Salomon Kans

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 May 8, 1912 Chas W. Whipple
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Elsworth Kans DATE OF BURIAL 3/21, 1912
 UNDERTAKER A. H. Haden ADDRESS Higginsville

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JUDICIAL DEPARTMENT

Revised United States Standard Certificate of Death

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

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