

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

County Liverington
 Township Morrisville
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 510 File No. 10038
 Primary Registration District No. 5679 Registered No. 3

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

FULL NAME William P. T. Walker

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| SEX <u>Male</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED <u>Widowed</u> (Write the word) | DATE OF DEATH <u>March</u> <u>12</u> " <u>1912</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>October</u> <u>30</u> , <u>1838</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from <u>December</u> , 1911, to <u>March 10</u> " 1912, that I last saw him alive on <u>March 10</u> " 1912, and that death occurred, on the date stated above, at <u>2 a.m.</u> | |
| AGE <u>73</u> yrs. <u>4</u> mos. <u>12</u> ds. | | IF LESS than 1 day, ___ hrs. or ___ min.? | The CAUSE OF DEATH* was as follows: <u>Organic Heart Disease</u> | |
| 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>same</u> | | | <u>7 1/2 yrs.</u> <u>1 yr. 10 mos.</u> (Duration) ___ yrs. ___ mos. ___ ds. | |
| BIRTHPLACE (City or town, State or foreign country) <u>Mo 1-02</u> | | | Contributory <u>Neuralgia</u> (SECONDARY) (Duration) <u>1 yr.</u> ___ mos. ___ ds. | |
| PARENTS | NAME OF FATHER <u>William Walker</u> | | (Signed) <u>Chas. Patton</u> M. D. <u>Mar 12</u> " 1912 (Address) <u>Morrisville, Mo</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</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>Rachel Hendricks</u> | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds. | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u> | | Where was disease contracted if not at place of death? Former or usual residence _____ | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo Walker</u> (ADDRESS) <u>Morrisville Mo</u> | | | | |
| Filed <u>March 13</u> 1912 <u>Chas Patton</u> REGISTRAR | | | PLACE OF BURIAL OR REMOVAL <u>Grave Cem</u> | |
| | | | DATE OF BURIAL <u>Mar 13</u> " 1912 | |
| | | | UNDERTAKER <u>None</u> | |
| | | | ADDRESS <u>None</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, peritonacum*, 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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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
 County, Livingston
 Township, Mooreville
 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. 310 File No. _____
 Primary Registration District No. 5679 Registered No. 3

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

FULL NAME William P. T. Wacker

PERSONAL AND STATISTICAL PARTICULARS

SEX m **COLOR OR RACE** w **SINGLE MARRIED WIDOWED OR DIVORCED** wd
(Write the word)

DATE OF BIRTH
Oct 30, 1938
(Month) (Day) (Year)

AGE
73 yrs. 4 mos. 12 ds.
If LESS than 1 day, ____ hrs. or ____ min.

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

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

PARENTS

| | |
|----------------------------------------------------------------------------------------|-------------------------|
| NAME OF FATHER | <u>William Wacker</u> |
| BIRTHPLACE OF FATHER <small>(City or town, State or foreign country)</small> | <u>N.C.</u> |
| MAIDEN NAME OF MOTHER | <u>Rachel Hendricks</u> |
| BIRTHPLACE OF MOTHER <small>(City or town, State or foreign country)</small> | <u>Mo.</u> |

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) George Wacker
 (ADDRESS) Mooreville Mo

File X Mar 13, 1922 C. W. Patton
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 12, 1922
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1912, that I last saw him alive on Mar 10, 1922, and that death occurred, on the date stated above, at 2 A.

The **CAUSE OF DEATH*** was as follows:
Organic Heart Disease

Contributory Gastralgia
(SECONDARY)
 (Duration) 1 yrs. 6 mos. _____ ds.
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) X _____, 1912 (Address) Mooreville Mo
 _____ M. D.

*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 <u>Daunt Cem</u> | DATE OF BURIAL <u>3/13, 1922</u> |
| UNDERTAKER <u>none</u> | ADDRESS <u>none</u> |

Revised United States Standard Certificate of Death

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

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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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