

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.

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

PLACE OF DEATH Shelby  
County Black Creek Registration District No. 831 File No. 38039  
Township \_\_\_\_\_ or \_\_\_\_\_ Primary Registration District No. 6092 Registered No. 28  
Village \_\_\_\_\_ or \_\_\_\_\_ City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME No Name Infant's Birth

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Female</u>	COLOR OR RACE <u>Caucasian</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)	DATE OF DEATH <u>Nov</u> <u>9<sup>th</sup></u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Nov</u> <u>4</u> , 191 <u>2</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Nov 4</u> , 191 <u>2</u> , to <u>Nov 9</u> , 191 <u>2</u> , that I last saw her alive on <u>Nov 8<sup>th</sup></u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>1/16</u> m.	
AGE _____ yrs. _____ mos. <u>4</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Failure of Feated Heart</u> <u>To Close, 6 1/2 to 7 mo</u> <u>with Child</u> <u>1570</u> (Duration) <u>7</u> yrs. <u>9</u> mos. _____ ds. <u>159</u> Contributory <u>4</u> <u>4</u> <u>10</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>XX O</u>			(Signed) <u>J. L. Weagin</u> M. D. <u>Nov 9<sup>th</sup> 1912</u> (Address) <u>Shelbyville Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Shelby Co</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>Clyde Green</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 FATHER (City or town, State or foreign country) <u>Brown Co Ill</u>		Where was disease contracted If not at place of death? Former or usual residence _____	
	MAIDEN NAME OF MOTHER <u>Genobia Tomlinson</u>		PLACE OF BURIAL OR REMOVAL <u>Shelbyville, D. O. P. County</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Lewis Co Mo</u>		DATE OF BURIAL <u>Nov 10</u> , 191 <u>2</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clyde Green</u> (ADDRESS) <u>Shelbyville Mo</u>			UNDERTAKER <u>J. W. Thompson</u>	
Filed <u>Nov 14</u> , 191 <u>2</u> <u>W. Carson</u> REGISTRAR			ADDRESS <u>Shelbyville Mo</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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PLACE OF DEATH

County Shelby  
 Township Black Creek  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CERTIFICATE OF DEATH

Registration District No. 831 File No. 38039  
 Primary Registration District No. 6092 Registered No. 28

FULL NAME no name - Premature Birth. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>F</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Nov 4, 1912</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>4</u> ds.		If LESS than 1 day, _____ hrs. or _____ mln.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Shelby Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Clyde Greene</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ill</u>	
	MAIDEN NAME OF MOTHER <u>Jessie Lou Tucker</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo. Co. Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 9, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 4, 1912, to Nov 9, 1912, that I last saw her alive on Nov 9, 1912, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH\* was as follows:  
Failure of Fetal Heart to close 6 1/2 or 7 mo. uterine -

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY)  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. H. Thompson M. D.  
Nov 9, 1912 (Address) Shelbyville 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. \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde Green  
 (ADDRESS) Shelbyville Mo

Filed 1-6-1913 W. H. Carson REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Old Fellows Cem</u>	DATE OF BURIAL <u>Nov 10, 1912</u>
UNDERTAKER <u>J. H. Thompson</u>	ADDRESS <u>Shelbyville Mo</u>

Original file, date 9 1912 All information called for must be written on this Supplementary Certificate.

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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 *septicchaemia*," "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.)