

N. 1. Every item of information should be entered in plain terms, so that it may be understood by all persons. AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Putnam  
 Township Virginia  
 or State  
 Village State  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 655 File No. 40118  
 Primary Registration District No. 5872 Registered No. 36

FULL NAME Unnamed Infant

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

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Boy</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>
DATE OF BIRTH <u>Dec 20, 1912</u> <small>(Month) (Day) (Year)</small>		
AGE <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. <small>IF LESS than 1 day, ___ hrs. or ___ min.?</small>		
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>None</u>		
BIRTHPLACE (City or town, State or foreign country) <u>near Stee MO</u>		
PARENTS	NAME OF FATHER <u>Robt M. Roy</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Stobans Ark</u>	
	MAIDEN NAME OF MOTHER <u>Lillie Tedder</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ark</u>	

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH <u>Dec 22, 1912</u> <small>(Month) (Day) (Year)</small>
I HEREBY CERTIFY, that I attended deceased from <u>X</u> , 191 <u>2</u> , to <u>X</u> , 191 <u>2</u> , that I last saw h. <u>X</u> alive on <u>X</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>15 1/2</u> <u>cause of death of weakness of Infants (Institution)</u> <small>(Duration) _____ yrs. _____ mos. <u>2</u> ds.</small>
Contributory (SECONDARY) _____ <small>(Duration) _____ yrs. _____ mos. _____ ds.</small>
(Signed) <u>J. W. Robbins</u> M. D. <u>Depts Stee MO</u> <small>*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.</small>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Robt M Roy  
 (ADDRESS) Stee MO  
 Filed Dec 23, 1912 N. J. Turner  
 REGISTRAR

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>Funerary</u>	DATE OF BURIAL <u>Dec 23, 1912</u>
UNDERTAKER <u>Family Burial</u>	ADDRESS <u>Stee, 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*, *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.)

HUGH STEPHENS, JEFFERSON CITY.



MARGIN RESERVED FOR BINDING

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

Fully and exactly as stated EXACTLY. PHYSICIAN to be certified. Exact statement of OCCUPATION to be given.

MISSOURI STATE BOARD OF HEALTH

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

PLACE OF DEATH  
 County Pemissot  
 Township Virginia  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 655 File No. \_\_\_\_\_  
 Primary Registration District No. 5872 Registered No. 36

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

FULL NAME unnamed infant

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Boy</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
DATE OF BIRTH <u>Dec. 20</u> , 19 <u>12</u> (Month) (Day) (Year)		
AGE <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>near Steele Mo.</u>		
PARENTS	NAME OF FATHER <u>Robert M. Roy</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ark.</u>	
	MAIDEN NAME OF MOTHER <u>Lilla Teddie</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ark.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Dec. 22, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_; that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ a.m.

The CAUSE OF DEATH\* was as follows:  
Unknown   
No Physician in attendance   
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) [Signature] M. D.  
Dec. 23 1912 (Address) Steele, 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) Robt. M. Roy  
 (ADDRESS) Steele, Mo.

Filed Dec 23 1912  
 REGISTRAR [Signature]

PLACE OF BURIAL OR REMOVAL  
Green Cem.

DATE OF BURIAL  
Dec. 23 1912

UNDERTAKER  
Family Burial

ADDRESS  
Steele Mo.

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

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