

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	
County <u>St. Francis</u>		BUREAU OF VITAL STATISTICS	
Township <u>Raidolph</u>		CERTIFICATE OF DEATH	
or		Registration District No. <u>774</u>	File No. <u>14268</u>
Village		Primary Registration District No. <u>6024-a</u>	Registered No. <u>29</u>
or		(NO. _____) St. _____	Ward _____
FULL NAME <u>Frank Williams</u>			

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M</u>	COLOR OR RACE <u>W</u>	MARITAL STATUS SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>April 7</u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Apr 7</u> , 18 <u>55</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Mar 7</u> , 191 <u>3</u> to <u>Apr 3</u> , 191 <u>3</u>	
AGE <u>58</u> yrs. ___ mos. ___ ds.			that I last saw him alive on <u>Apr 3</u> , 191 <u>3</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u>			and that death occurred, on the date stated above, at <u>3 P.M.</u>	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>2007</u>			The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Tennessee</u>			<u>23A</u>	
PARENTS	NAME OF FATHER <u>Joseph Williams</u>		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Tennessee</u>		(Signed) <u>E. P. McCalland</u> M. D. <u>4/7</u> , 191 <u>3</u> (Address) <u>Desloge, Mo.</u>	
	MAIDEN NAME OF MOTHER <u>M. Maberry</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn.</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			Where was disease contracted if not at place of death? _____	
(Informant) <u>Martha Williams</u>			Former or usual residence _____	
(ADDRESS) <u>Desloge, Mo.</u>			PLACE OF BURIAL OR REMOVAL <u>W. of P. Cem. Desloge</u>	
Filed <u>April 9</u> , 191 <u>3</u> <u>E. P. McCalland</u> REGISTRAR			DATE OF BURIAL <u>4/9</u> , 191 <u>3</u>	
			UNDERTAKER <u>J. A. Boyer</u>	
			ADDRESS <u>Leadwood, Mo.</u>	

WITH THE BUREAU OF VITAL STATISTICS
REVISIONS TO THE 1910 CENSUS REPORT

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*, *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.)



WITH UNFADING INK - THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County St. Francois
Township Randolph
Village _____
or _____
City _____ (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. 779 File No. _____
Primary Registration District No. 6024-a Registered No. 29

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

FULL NAME

Frank Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) m
DATE OF BIRTH Apr. 7, 1855
(Month) (Day) (Year)
AGE 58 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

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

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

PARENTS NAME OF FATHER Jos. Williams BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.
MAIDEN NAME OF MOTHER Mabery BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Martin Williams Satisfactory information supplied.

(ADDRESS) DeLoage, Mo

Filed 4/9 1913 E. M. McClelland REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 7, 1913
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Mar 7, 1913, to Apr. 3, 1913, that I last saw him alive on 4 " 1913, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. M. McClelland M. D. 4/7 1913 (Address) DeLoage, 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? Satisfactory information supplied
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL To of DeLoage DATE OF BURIAL _____ 1913

UNDERTAKER Satisfactory information supplied ADDRESS _____

Revised United States Standard Certificate of Death

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

80271

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