

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

County _____

Township _____

or Village _____

or City Meris (NO. _____)

Registration District No. 791

File No. 30972

Primary Registration District No. 1003

Registered No. 7995

City City Hospital St. 6 Ward

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

FULL NAME Joe Morris

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (If write the word)
DATE OF BIRTH <u>April 1, 1868</u> (Month) (Day) (Year)		
AGE <u>45</u> yrs. <u>4</u> mos. <u>27</u> 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) Day

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

PARENTS

NAME OF FATHER <u>John Juhier</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>France</u>
MAIDEN NAME OF MOTHER <u>Margaret Vincent</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>France</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edouard Korman

(ADDRESS) City Hospital

Filed SEP -3 1913 Maub Starkloff REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 28, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY that I attended deceased from July 16, 1913, to Aug 28, 1913 that I last saw him alive on Aug 28, 1913 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Post-Operative Shock
(Nephrectomy)
30 (Duration) yrs. mos. ds.

Contributory (SECONDARY) _____
(Duration) yrs. mos. ds.
(Signed) Frederic Hagler M. D.
Aug 29, 1913 (Address) City Hospital

*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 13 yrs. 10 mos. 10 ds. State 10 yrs. 10 mos. 10 ds.
Where was disease contracted if not at place of death?
Former or usual residence 107 D

PLACE OF BURIAL OR REMOVAL POTTERS FIELD. DATE OF BURIAL SEP -3 1913

UNDERTAKER Misselman ADDRESS 1426 Carroll

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*, *Sarcoma*, etc., of (name only; "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.)

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

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

County _____
Township _____ or Village _____ or City _____
Registration District No. 191 File No. _____
Primary Registration District No. 1003 Registered No. 7995
St.: _____ Ward) _____

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

FULL NAME

Joe Morris

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Satisfactory Information Supplied
AGE _____ yrs. _____ mos. _____ ds.

DATE OF DEATH 9-28-1913
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* was as follows:
Post-operative Shock
(Bilateral Lung Kidney) X
(Duration) _____ yrs. _____ mos. _____ ds.

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

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Frederic Hoagler M.D.
9-29-1913 (Address) City Hospital

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Satisfactory Information Supplied

*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 _____

(ADDRESS) _____
Filed 1219 1913 G. W. Arnold REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____
Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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