

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

19988

PLACE OF DEATH
County Monroe
Township _____
or
Village _____
or
City California (NO. _____) St. _____ Ward _____

Registration District No. 571 File No. _____
Primary Registration District No. 4335 Registered No. 30

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

FULL NAME Charles M. Chase

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OF HAIR White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)
DATE OF BIRTH Apr 15 '51, 1851
(Month) (Day) (Year)
AGE 63 yrs. 3 mos. 0 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

PARENTS
NAME OF FATHER Thomas A Chase
BIRTHPLACE OF FATHER (City or town, State or foreign country) Idaho
MAIDEN NAME OF MOTHER Mary J. Emerson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Idaho

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas A Chase
(ADDRESS) St Louis, Mo

Filed June 6, 1914 by Mrs. H.S. Dove REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 6, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 4, 1914 to June 6, 1914, that I last saw him alive on June 6, 1914, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
131 Paralysis
87 D
Chronic Intestinal Neoplasia
(Duration) ____ yrs. ____ mos. 6 ds.

Contributory (SECONDARY) _____
(Signed) [Signature] M. D.
June 6, 1914 (Address) California 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 _____

PLACE OF BURIAL OR REMOVAL Maconic Cem DATE OF BURIAL June 7, 1914
UNDERTAKER William Longan ADDRESS California Mo

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 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," "Hæmorrhage," "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

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

County Monitau Registration District No. 571 File No. _____
 or _____ Primary Registration District No. 4335 Registered No. 30
 Village California St.: _____ Ward) _____
 or _____
 City _____
 FULL NAME Charles M Chase [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED M.
(Write the word)

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ 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) _____

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) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed X _____ 191____ REGISTRAR X

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 5, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw h _____, 191____,
 and that death occurred, on the _____ stated above, at _____ m.
 The CAUSE OF DEATH* was as follows:
Paralysis of the bladder
Chronic Intestinal Nephritis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. K. Pope M.D.
6-6-14 (Address) California 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 _____

PLACES OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____
 UNDERTAKER _____ ADDRESS _____

JUN 1914

Original file, date _____ 19____ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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