

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

PLACE OF DEATH

County DeKalb Co
Township Grand River
or
Village
or
City

Registration District No. 984
Primary Registration District No. 5353

File No. 649
Registered No.

FULL NAME Charles H. Greene

[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 Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF DEATH Jan 9, 1915
(Month) (Day) (Year)

DATE OF BIRTH February 24, 1851
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 23, 1914, to Jan 1st, 1915, that I last saw him alive on Jan 1st, 1915, and that death occurred, on the date stated above, at 5:30 pm.

AGE 63 yrs. 10 mos. 9 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

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

Cerebral Hemorrhage

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

PARENTS
NAME OF FATHER Frank Greene
BIRTHPLACE OF FATHER (City or town, State or foreign country) Vermont
MAIDEN NAME OF MOTHER Ada Bacon
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

Contributory (SECONDARY) W
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) J. A. Franklin M. D.
Jan 9, 1915 (Address) Cameron

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas H. Greene
(ADDRESS) Cameron Mo

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

Filed Jan 24, 1915 Chas O Sackett
REGISTRAR

PLACE OF BURIAL OR REMOVAL Packard Cem. DATE OF BURIAL Jan 4, 1915
UNDERTAKER J. B. Poland ADDRESS Cameron

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**

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____
 Primary Registration District No. _____

File No. _____
 Registered No. _____

(NO. _____)

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____
 COLOR OR RACE _____
 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 AGE _____ (Month) _____ (Day) _____ (Year)
 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) _____

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 _____, 191____, REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) 191____

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 _____, m. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) _____ yrs. _____ mos. _____ ds. (Duration)
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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 _____ DATE OF BURIAL _____, 191____
 UNDERTAKER _____ ADDRESS _____

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.

County De Kalb Registration District No. 984 File No. 15363
Township Grandriver Primary Registration District No. 15363 Registered No.
Village City (NO. St. Ward)

FULL NAME Charles M. Green

(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 M MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH (Month) 1 (Day) 1915 (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 Jan 1 1915 Chas O Sackett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 1 1915 (Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from , 1915, to , 1915, that I last saw him , 1915.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage
X 64 X
Duration yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.
(Signed) J. A. Stronker M.D. (Address) Cameron

*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 DATE OF BURIAL 1915

UNDERTAKER J. W. Poland ADDRESS Cameron

SUPPLEMENTARY

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.

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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

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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.)