

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

PLACE OF DEATH

County Scott

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Sebeston Mo (NO. \_\_\_\_\_)

Registration District No. 821

File No. 7032

Primary Registration District No. 4553

Registered No. 91

St.: \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME John Luke Chaffetter

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Child  
(Write the word)

DATE OF DEATH Feb 10 - 1915  
(Month) (Day) (Year)

DATE OF BIRTH October 19, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1 - 1915, to Feb 9 - 1915, that I last saw him alive on Feb 9 - 1915, and that death occurred, on the date stated above, at 100 m.

AGE 1 yrs. 3 mos. 10 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Tubercular Meningitis

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

23A  
29A

BIRTHPLACE (City or town, State or foreign country) Sebeston Mo

NAME OF FATHER William Chaffetter

BIRTHPLACE OF FATHER (City or town, State or foreign country) Jackson Mo

MAIDEN NAME OF MOTHER Heuler

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Sebeston Mo

(Duration) 3 yrs. 9 mos. 9 ds.

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

(Signed) W. W. Mayfield M. D.  
Feb 11 - 1915 (Address) Sebeston 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Frank Heuler

Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

(ADDRESS) Sebeston Mo

PLACE OF BURIAL OR REMOVAL Sebeston DATE OF BURIAL 2-11-1915

Filed \_\_\_\_\_ 191 \_\_\_\_\_ REGISTRAR

UNDERTAKER Geo. Albritton ADDRESS Sebeston Mo

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

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.)

## PLACE OF DEATH

County

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

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

Township

Registration District No.

File No.

or  
Village

Primary Registration District No.

Registered No.

City

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

FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH

DATE OF BIRTH

AGE

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

1915

REGISTRAR

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

The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

Contributory

(SECONDARY)

(Signed) \_\_\_\_\_

(Address) \_\_\_\_\_

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Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_

DATE OF BURIAL

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Original file, date

All information called for must be written on this Supplementary Certificate.

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