

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important.

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

*Spider*

1 PLACE OF DEATH  
County *Linn*  
Township *Salem*  
or  
Village  
or  
City (NO. St. Ward)

Registration District No. *290* File No. *8111*  
Primary Registration District No. *5408* Registered No. *21*

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

2 FULL NAME *Ramon Sappington*

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *single*

6 DATE OF BIRTH: *August 26 1910*  
(Month) (Day) (Year)

7 AGE *4 yrs. 6 mos. 5 ds.* 8 LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Laclede County*

PARENTS  
10 NAME OF FATHER *W.D. Sappington*  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Boone County Mo*  
12 MAIDEN NAME OF MOTHER *Edmond Miller*  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Franklin Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) *W.D. Sappington*  
(Address) *Salem Mo.*

15 Filed *3/30 1915* *B.J. Browning*  
Registrar

**2 MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH *3 3 1915*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Feb 22 1915* to *March 3 1915*, that I last saw him alive on *March 3 1915*, and that death occurred, on the date stated above, at *12 a.* m.

The CAUSE OF DEATH was as follows:  
*Phuritis and Pneumonia*  
*108*  
*110 D* (Duration) yrs. mos. *9* ds.

CONTRIBUTORY (Secondary) *8* (Duration) yrs. mos. ds.  
(Signed) *T. H. Seidel* M. D.  
*3-4 - 1915* (Address) *Snato Mo*

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

18 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.

19 PLACE OF BURIAL OR REMOVAL *St. Paul* DATE OF BURIAL *1915*

20 UNDERTAKER ADDRESS

# 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*, *Composer*, *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," "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 *septicæmia*," "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

BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

County Franklin  
 Township Salun  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 290 File No. \_\_\_\_\_  
 Primary Registration District No. 5408 Registered No. 21

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

FULL NAME Ramon Supprington

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
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) _____	

DATE OF DEATH 3-3, 1912  
 (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.

The CAUSE OF DEATH\* was as follows:  
Fluents and Pneumonia  
Labor Pneumonia

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

(Signed) H. H. Spindel M. D.  
 1912 (Address) Senatemo

\*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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_  
 Filed 3/30 1912 H. H. Spindel REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
 UNDERTAKER H. P. McDaniel ADDRESS Senatemo

SATISFACTORY INFORMATION SUPPLIED BY \_\_\_\_\_  
 SUPPLEMENTARY

RECEIVED  
 MARCH 3-3 1912

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