

MARGIN RESERVED FOR BONDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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 Cole

12010

Township _____

Registration District No. 213-

File No. _____

or Village _____

Primary Registration District No. 3014-

Registered No. 56-

or City Jefferson (NO. St. Mary's Hosp. St. _____ Ward)

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

FULL NAME

Jno. Supak

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE MARRIED single WIDOWED OR DIVORCED (If wife the word)

DATE OF BIRTH

June 15, 1896
(Month) (Day) (Year)

AGE

18 yrs. ____ mos. ____ ds.

IF LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work

Salvager

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country)

Bohemia

PARENTS

NAME OF FATHER

Jno. Supak

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

Bohemia

MAIDEN NAME OF MOTHER

Don't Know

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

Bohemia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Supak

(ADDRESS) St. Louis Mo.

Filed April 5-1, 1915 D. B. Bueford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Mar. 28, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 27, 1915, to Mar 28, 1915, that I last saw him alive on Mar 27, 1915, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

concussion of Brain fractured skull
209 P
209 M (Duration) ____ yrs. ____ mos. 27 ds.

Contributory (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

W. W. Clark M. D.
Mar 29, 1915 (Address) Jeff. City 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

City Cemetery

DATE OF BURIAL

Apr 5, 1915

UNDERAKER

A. H. Amiche Jeff City

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 _____ (NO. _____)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered 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) _____, 191____ (Day) _____, 191____ (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) _____

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) _____, 191____ (Day) _____, 191____ (Year) _____
 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:
 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Signed) _____ M. D.
 _____, 191____ (Address) _____

Contributory (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Signed) _____ M. D.
 _____, 191____ (Address) _____

*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 _____, 191____

UNDERTAKER _____

ADDRESS _____

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.

PLACE OF DEATH

County Coll

Township _____

Registration District No. 213

File No. _____

Village _____

Primary Registration District No. 3014

Registered No. 56

City Jefferson City

St. Marys Hosp

Ward) _____

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

FULL NAME Jno. Super

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____
(Month) (Day) (Year)

AGE _____
If LESS than 1 day, hrs _____ or min _____
mos. ds.

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (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 4/1 1915

4-3 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 28 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive _____ 191____, and that death occurred, on the date stated above; at _____ m.

The CAUSE OF DEATH* was as follows:
Concussion of Brain
fractured skull
By falling from moving train
(Duration) _____ yrs. _____ mos. 2 ds.

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

(Signed) W. A. Clark M. D.
May 29 1915 (Address) Jeff. City, 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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERM

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is required.

Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

Original file, date Apr 15 1915 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]

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

91021
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.)