

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

PLACE OF DEATH  
County Iron  
Township Armadia Registration District No. 390 File No. 18888  
or Middlebrook Mo. Primary Registration District No. 5546B Registered No. 4  
City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME John Meyer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write "Widowed" if divorced)

DATE OF DEATH June 8, 1915  
(Month) (Day) (Year)

DATE OF BIRTH Jan. - 5<sup>th</sup> 1829  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 8, 1915, to June 8, 1915, that I last saw him alive on June 8, 1915,

AGE 86 yrs. 6 mos. 3 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

and that death occurred, on the date stated above, at 12 Noon.

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

The CAUSE OF DEATH\* was as follows:  
Paralysis  
51 R  
22 R

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

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

PARENTS  
NAME OF FATHER Do not know  
BIRTHPLACE OF FATHER Germany  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER Do not know  
BIRTHPLACE OF MOTHER Germany  
(City or town, State or foreign country)

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) R. W. Gay M. D.  
(Address) Fronton, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Thomas G. Meyer

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

(ADDRESS) Bigfork, Mo.

PLACE OF BURIAL OR REMOVAL Middlebrook Mo. DATE OF BURIAL June 9, 1915

Filed June 8, 1915 Lizzie J. Effinger REGISTRAR

UNDERTAKER Alveta Dow ADDRESS Fronton, Mo.

This form should be carefully supplied. AGE should be stated EXACTLY in years, months and days. Exact statement of OCCUPATION should be given.

# 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

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.)

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

1 PLACE OF DEATH  
County Dow  
Township Aradia  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_ (NO \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 392 File No. \_\_\_\_\_  
Primary Registration District No. 5546 B Registered No. 7

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

2 FULL NAME John Meyer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED M  
(Write the word)

6 DATE OF BIRTH \_\_\_\_\_ 1 \_\_\_\_\_ (Year)  
(Month) (Day)

7 AGE \_\_\_\_\_ If LESS than '1 day... hrs. or... min.?  
..... yrs. .... mos. .... ds.

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) \_\_\_\_\_

PARENTS  
10 NAME OF FATHER \_\_\_\_\_  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
12 MAIDEN NAME OF MOTHER \_\_\_\_\_  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(Address) \_\_\_\_\_

Filed June 8 1915 Lizzie J. Ellinger  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8 1915  
(Month) (Day) (Year)

17 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:  
Paralysis  
Bulbar Paralysis  
64  
Duration \_\_\_\_\_ yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage  
(Duration) \_\_\_\_\_ yrs. .... mos. .... ds.  
(Signed) R. N. Gay M. D.  
June 8 1915 (Address) Ironville 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 \_\_\_\_\_ STATE OF BURIAL \_\_\_\_\_ 191 \_\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY Information Supplied.

PHYSICIANS should state in full terms, so that it may be properly classified. Exact statement should be given. Every item of information should be given. CAUSE OF DEATH in plain language.

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*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), 29ds.; *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.)

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