

Should state very important.

Williams

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

1 PLACE OF DEATH

County ~~Butler~~ *Butler*
Township *Border*
or
Village
or
City

Registration District No. *89*
Primary Registration District No. *5731*

File No. *13672*
Registered No. *77*

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

2 FULL NAME *Ezekiel Miller*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*
4 COLOR OR RACE *White*
5 SINGLE MARRIED *married*
WIDOWED OR DIVORCED
(Write the word)

6 DATE OF BIRTH *March 4 1845*
(Month) (Day) (Year)

7 AGE *71* yrs. mos. ds.
If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE
(City or town, State or foreign country) *Wayne Co Mo*

PARENTS
10 NAME OF FATHER *Fredrick Miller*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Dont know*
12 MAIDEN NAME OF MOTHER *Dont know*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Dont know*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Fred E Miller*
(Address) *Poplar Bluff Mo*

15 Filed *April 5th 1916* *Natie Elle* Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *April 2 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Feb 6th 1916* to *April 2 1916* that I last saw him alive on *March 20th 1916* and that death occurred, on the date stated above, at *6:30 P.M.*
The CAUSE OF DEATH* was as follows:

Prostatitis
23A (Pulmonary Tuberculosis)
10/6/13 (Duration) *2* yrs. mos. ds.

CONTRIBUTORY *Chronic Bronchitis*
(Secondary) (Duration) *15* yrs. mos. ds.
(Signed) *Dr. W. Williams M.D.*
April 3, 1916 (Address) *Poplar Bluff 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 *Statenby Cemetery* DATE OF BURIAL *April 4, 1916*
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*, *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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY the cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should state the nature of the occupation. If the deceased was a transient, the name of the place where he died should be stated. If the deceased was a patient in a hospital or institution, the name of the hospital or institution should be stated.

1 PLACE OF DEATH

County Butter Registration District No. 89 File No. 11
 Township Beaver Dam or Village Beaver Dam Primary Registration District No. 5131 Registered No. 11
 City (NO) St. (NO) Ward (NO)

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

2 FULL NAME

Ezekiel Miller

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---|--|
| 3 SEX <u>M</u> | 4 COLOR OR RACE <u>W</u> | 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u> |
| 6 DATE OF BIRTH <u>1870</u> (Month) <u>11</u> (Day) <u>1</u> (Year) | | |
| 7 AGE <u>46</u> yrs. <u>0</u> mos. <u>0</u> ds. | | IF LESS than 1 day... hrs. <u>0</u> or min. <u>0</u> |
| 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) | |

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Apr. 7 1916
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 1916 to 1916
 that I last saw him alive on 1916
 and that death occurred, on the date stated above, at m.
 The CAUSE OF DEATH* was as follows:
Satisfactory
 (Duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) (Duration) 0 yrs. 0 mos. 0 ds.
 (Signed) (Address) 1916 M. D.

*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 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
 Where was disease contracted if not at place of death?
 Former or usual residence (Address)

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

15 Filed April 5th 1916, Kate Ellis Registrar

19 PLACE OF BURIAL OR REMOVAL Salt's DATE OF BURIAL 1916
 20 UNDERTAKER Franks ADDRESS Peplas Bu...

Original file, date APR 1916

All 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]

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