

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

31627

1 PLACE OF DEATH  
County Laurie  
Township .....  
or .....  
Village .....  
or W. Vernon  
City ..... (NO. .... St. .... Ward) .....

Registration District No. 470 File No. ....  
Primary Registration District No. 4289 Registered No. 98

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

2 FULL NAME Samuel R. Wright

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Jan 16 1878  
(Month) (Day) (Year)

7 AGE 88 yrs 7 mos 17 ds. If LESS than 1 day, .... hrs. or .... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Canada

PARENTS  
10 NAME OF FATHER Amos Wright  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known  
12 MAIDEN NAME OF MOTHER Emmie Brown  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. W. Lobbers  
(Address) W. Vernon Mo

15 Filed Sept 4 1916 E. G. Knapp  
Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 3 1916  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 29 1916 to Aug 29 1916  
that I last saw him alive on Aug 29 1916  
and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH\* was as follows:  
Acute Heart failure  
Due to general arteriosclerosis  
following 4 months of partial  
amputation (Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) None  
(Duration) .... yrs. .... mos. .... ds.  
(Signed) C. W. Shelton M. D.  
191 (Address) W. Vernon 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 Goss Cem DATE OF BURIAL Sept 4 1916

20 UNDERTAKER Clyde Hocker ADDRESS W. Vernon Mo

# 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.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms. Exact statement of OCCASION of DEATH should be given for chronic states. If death occurred in hospital or institution, give its NAME instead of street and number.

1 PLACE OF DEATH

County Lawrence  
 Township or  
 Village or  
 City Mt Vernon (NO. .... St. .... Ward)

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

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

Registration District No. H70 File No. ....  
 Primary Registration District No. H283 Registered No. 38

2 FULL NAME Samuel P. Wright.

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 1 (Year) Satisfactory Information Supplied

7 AGE If LESS than 1 day..... hrs. or..... min.? yrs..... mos..... Satisfactory Information Supplied

8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) Satisfactory Information Supplied

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) Satisfactory Information Supplied

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

15 Filed SEP 10 1916 E. L. Knight Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191 (Year) Sept. 3 1916

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) 191 (Year) that I last saw h..... alive on..... 191 (Year) and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows: Acute Heart failure  
Age and general debility  
 (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) (Duration)..... yrs..... mos..... ds. (Signed) C. W. Seltzer M. D. 9/3 1916 (Address) Mt. Vernon 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..... Satisfactory Information Supplied

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 191 (Year) ADDRESS 20 UNDERTAKER Satisfactory Information Supplied

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Association]

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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 inter-current) 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.)