

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

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. 1002
 Township Springfield Mo. Primary Registration District No. 3031 Registered No. 86
 City Springfield Mo. (No. Arised. Hospital) St. _____ Ward)

2. FULL NAME

(a) Residence. No. At Scott Kaw. St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
18 5 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.
 (b) General nature of industry, business, or establishment in which employed (or employer) R.P. Co.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) At Scott Kansas
 (STATE OR COUNTRY)

10. NAME OF FATHER Nathan Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Norma Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kansas
 (STATE OR COUNTRY)

14. INFORMANT Nathan Brown
 (Address) At Scott Kaw.

15. JAN 31 1919 Edwin F. James REGISTRAR
Debbie B. Brown Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 1/31 - 1919

17. I HEREBY CERTIFY, That I attended deceased from 1/30 - 1919 to 1/31 - 1919
 that I last saw deceased alive on 1/31 - 1919, and that death occurred, on the date stated above, at 5:30 AM.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tetanus
 (duration) _____ yrs. _____ mos. 4 ds.

CONTRIBUTORY (SECONDARY) _____
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED At Scott Kansas
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Emm. Sessenden, M.D.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL At Scott Kaw. DATE OF BURIAL Feb 2 1919

20. UNDERTAKER Chambers Undert Co ADDRESS 305 N. Walnut

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, 8 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

E. M. Henderson

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 86
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1919

17. I HEREBY CERTIFY, That I attended deceased from 1/30 1919, to 1/31 1919 that I last saw him alive on 1/31 1919, and that death occurred, on the date stated above, at 3:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tetanus
Nail wound in foot
(accidental) (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: H Scott Kana

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS: clinical

✓ (Signed) E. M. Henderson, M. D.

4-4, 1919 (Address) Springfield, Mo.

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14. INFORMANT (Address) _____

15. APR 5 - 1919 FILED _____ 19 _____ REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY

Edwin James
Dollie B. Johnson
Deputy Registrar

Revised United States Standard Certificate of Death

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

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