

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

1 PLACE OF DEATH

County Berry  
Township Jenifer  
Village Jenifer  
City Jenifer

Registration District No. 973 File No. 21580

Primary Registration District No. 5049 Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

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

2 FULL NAME

Horrie Williams

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OF RACE White SINGLE  MARRIED  married WIDOWED OR DIVORCED (Write the word)

16 DATE OF DEATH July 19, 1919  
(Month) (Day) (Year)

DATE OF BIRTH March 19, 1885  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended attending on July 20, 1919, to 7:20, 1919, that I last saw him on July 20, 1919, and that death occurred, on the date stated above, at 9 a m.

AGE 34 yrs 4 mos 4 ds IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Gunshot Wound  
Fired by Sidney Milton  
Penetrated Left Lung  
193 (Duration) yrs. mos. ds.

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

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

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

(Signed) J. M. Drinan, M. D.  
7 20, 1919 (Address) Jenifer

BIRTHPLACE (City or town, State or foreign country) Mo R.C.

\*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

10 NAME OF FATHER unknown

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

Where was disease contracted if not at place of death? \_\_\_\_\_

12 MAIDEN NAME OF MOTHER unknown

Former or usual residence \_\_\_\_\_

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

4 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE wife  
(Informant) Dore Williams  
(Address) catto mo

19 PLACE OF BURIAL OR REMOVAL Clio Cemetery DATE OF BURIAL July 20, 1919

5 Filed July 20, 1919 Registrar J. M. Drinan

20 UNDERTAKER P. E. Hoins ADDRESS Collinsville

**LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT**

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

**1 PLACE OF DEATH**

County .....  
 Township ..... Registration District No. .... File No. ....  
 or .....  
 Village ..... Primary Registration District No. .... Registered No. ....  
 or .....  
 City ..... (NO ..... St. .... Ward) .....  
 If death occurred  
 hospital or institu-  
 give its NAME and  
 of street and numbe

**2 FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

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

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year) .....  
 If LESS than  
 1 day ..... hrs.  
 or ..... min.?

7 AGE ..... yrs. .... mos. .... ds.  
 by ..... (Day) ..... (Year) .....  
 If LESS than  
 1 day ..... hrs.  
 or ..... min.?

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)

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) .....

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH ..... (Month) ..... (Day) ..... 191 (Year) .....  
 17 I HEREBY CERTIFY, that I attended deceased from  
 ..... 191 to ..... 191  
 that I last saw h ..... alive on .....  
 and that death occurred, on the date stated above, at .....  
 The CAUSE OF DEATH\* was as follows:

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

\*State the Disease Causing Death, or, in deaths from Violent Causes, the  
 (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 ..... DATE OF BURIAL ..... 191  
 20 UNDERTAKER ..... ADDRESS .....

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

1. PLACE OF DEATH  
 County Boone Registration District No. 973 File No. 21580  
 Township Genius Primary Registration District No. 5048 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Horne Williams  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

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) \_\_\_\_\_

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 8/20 1919 S. M. Periman REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1919

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Gunshot wound  
caused by Alvin Mason  
General of First Army  
**Homicide** (duration) yrs. mos. da.  
 CONTRIBUTORY 55 target rifle (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_ (Signed) S. M. Periman, M. D. July 20 1919 (Address) Genius

\*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 Ohio mo DATE OF BURIAL July 21 1919  
 20. UNDERTAKER L. Henson ADDRESS Colo

SUPPLEMENTARY

# 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"); *Labar 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 gives 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.

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

**1. PLACE OF DEATH**

County St. Louis Registration District No. 973 File No. \_\_\_\_\_  
 Township Rush Primary Registration District No. 5048 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Kornel Wellhaus  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

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 Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) F. M. Lyon  
 (c) Name of employer \_\_\_\_\_

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

PARENTS

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) \_\_\_\_\_

14. INFORMANT (Address) \_\_\_\_\_

15. FILED 10/19/10 J. M. O'Brien REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1919

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw \_\_\_\_\_, die on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_.

18. CAUSE OF DEATH\* WAS AS FOLLOWS:  
Gun shot wound  
caused by John Nixon  
General Post Office  
 CONTRIBUTORY (SECONDARY) Illness of the chest  
duration 2 to 3 weeks  
degree severe

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? yes  
 WHAT TEST CONFIRMED DIAGNOSIS? finding Bullet  
 (Signed) J. M. O'Brien, M. D.  
720, 1909 (Address) Jefferson

19. PLACE OF BURIAL, CREMATION, OR REMOVAL no DATE OF BURIAL \_\_\_\_\_ 19\_\_\_\_

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

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08512  
"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.)

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