

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

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29814-#

1. PLACE OF DEATH
 County Oregon Registration District No. 634 File No. 6
 Township Highland Primary Registration District No. 5837 Registered No. 6
 City (No. _____) _____ St. _____ Ward _____

2. FULL NAME Curtis Speck
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Scouria Speck

6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 | 2 | 12 |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farming
 (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) Penn

10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY) Unknown
 12. MAIDEN NAME OF MOTHER Anderson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY) Penn

14. INFORMANT Martha Anderson
 (Address) Flower Mo

15. FILED Jan 19 1921 Mrs. Cora M. Willard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21st 1920
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on July 26th, 1920, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of nose
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 45
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
 WAS THERE AN AUTOPSY: _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Dr. Shuttle, M. D.
 , 19 (Address) West Plains Mo

*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 Golfers cemetery DATE OF BURIAL Sept 22 1920

20. UNDERTAKER Wm Willard ADDRESS Flower Mo

important.

CAUTION

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*, *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.

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1. PLACE OF DEATH

County Oregon Registration District No. 634 File No. _____
 Township Highland Primary Registration District No. 5837 Registered No. 6
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Curtis Speck
 (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 (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 9 1855

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>51</u>	<u>2</u>	<u>12</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer (duration) yrs. mos. da.
 (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) Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Unknown

14. INFORMANT Margaret Anderson
 (Address) Peover Mo

15. FILED Jan 29 1921 Co. M Willard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1920

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw _____ live on July 26, 19____, and that death occurred on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer caused by growth in nose
Cancer of the Nose

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Dr. Shuttler, M. D.
 , 19____ (Address) Peover Mo

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Golf Cliff Cemetery Sept 22 1920
 20. UNDERTAKER Wm Willard ADDRESS Peover Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state SE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR THIS SUPPLEMENTARY.

SUPPLEMENTARY

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