

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

29086  
12

MAY 28 1925

**1. PLACE OF DEATH**

County Taney Registration District No. 859 File No. 304  
 Township Oliver Primary Registration District No. 6130 Registered No. \_\_\_\_\_  
 City Hollister (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Dorkey Stamps  
 (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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of May Stamps

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 2<sup>nd</sup> 1883

7. AGE YEARS MONTHS DAY II LESS than I day, hrs. or min.  
42 1 17

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Greene County Missouri  
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Charles Stamps

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

12. MAIDEN NAME OF MOTHER Lothie Sawickill

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

14. INFORMANT Charles Stamps  
 (Address) Republic Mo.

15. FILED Sept 19 1925 R B Hitt  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 19 1925

17. I HEREBY CERTIFY, That I attended deceased from Sept 18<sup>th</sup> 1925, to Sept 19<sup>th</sup> 1925, that I last saw him alive on Sept 18<sup>th</sup> 1925, and that death occurred, on the date stated above, at 8:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

B3A apoplexy

CONTRIBUTORY (SECONDARY) 74A  
 (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none  
 (Signed) Harry T. Evans, M.D.  
 , 19 (Address) Hollister 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 Branson Cemetery DATE OF BURIAL Sept 19 1925

20. UNDERTAKER T. L. Teon ADDRESS Hollister Mo.

N. B. This form should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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 neoplasma); *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 child-birth 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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

18

**1. PLACE OF DEATH**

County Platte Registration District No. 859 File No. 304  
 Township Platte Primary Registration District No. 6730 Registered No. \_\_\_\_\_  
 City Hallsville St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Word \_\_\_\_\_  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 19 1935

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF May Stamps

I HEREBY CERTIFY That I attended deceased from Sept 12 1935 to Sept 19 1935 that I last saw him living on Sept 18 1935 and that death occurred, on the date stated above, at 10:30 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 2 - 1883

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
42 1 17

Epilepsy  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession or particular kind of work Common laborer  
 (b) General nature of industry, business, or establishment in which employed (or employer) Labor  
 (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) none  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)  
Keene County Missouri

18. WHERE WAS DISEASE CONTRACTED 74A  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER Charles Stamps

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

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

19. WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? gross  
 Signed Harry Crans M. D.  
 \_\_\_\_\_, 19 35 (Address) Hallsville

12. MAIDEN NAME OF MOTHER Elizabeth Dunkle

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

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14. INFORMANT (Address) Charles Stamps  
Republic Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Transton Cemetery DATE OF BURIAL Sept 19 1935

15. FILED 46 19 35 for Hallsville

20. UNDERTAKER W. L. Poor ADDRESS Hallsville Mo

CAUSE 7.—Every item of information should be properly RECEIVED A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW REGISTRA

REGISTRAR

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