

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH	
1. PLACE OF DEATH County <u>Miller</u> Registration District No. <u>368</u> Township <u>Equality</u> Primary Registration District No. <u>3733</u> City _____ (No. _____) _____ St. _____ Ward _____ File No. <u>8971</u> Registered No. _____					2. FULL NAME <u>Geo. W. Cotton</u>	
(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.	
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>			16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>3/8</u> 19 <u>27</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Elizabeth Partridge</u>					17. I HEREBY CERTIFY, That I attended deceased from <u>2 20</u> , 19 <u>27</u> , to <u>3-8</u> , 19 <u>27</u> , that I last saw <u>him</u> alive on <u>3-5</u> , 19 <u>27</u> , and that death occurred, on the date stated above, at <u>4 p.m.</u>	
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>2-26-1856</u>					THE CAUSE OF DEATH WAS AS FOLLOWS: <u>1227</u> <u>Abortin</u> <u>59 Traumatized Hernia</u> (duration) <u>2</u> yrs. mos. ds.	
7. AGE	YEARS <u>71</u>	MONTHS	DAYS <u>12</u>	IF LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer					CONTRIBUTORY (SECONDARY) <u>1/80</u> (duration) _____ yrs. mos. ds.	
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ma</u>					18. WHERE WAS DEATH OCCURRING? IF NOT AT PLACE OF DEATH.	
PARENTS	10. NAME OF FATHER <u>W. S. Cotton</u>				1. DID AN OPERATION PRECEDE DEATH? <u>yes</u> DATE OF <u>2-15-27</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ind</u>				WAS THERE AN AUTOPSY? <u>no</u>	
	12. MAIDEN NAME OF MOTHER <u>Elizabeth Wilson</u>				WHAT TEST CONFIRMED DIAGNOSIS? <u>Symptom</u> (Signed) <u>B. M. Kow</u> M. D.	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ind</u>				, 19 (Address) <u>T. H. Kow</u>		
14. INFORMANT <u>Mrs. Geo. W. Cotton</u> (Address) <u>Sussex, Ind</u>					19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Wangle Cemetery</u>	
15. FILED <u>3/8/27</u> <u>B. M. Kow</u> REGISTRAR					DATE OF BURIAL <u>3/8</u> 19 <u>27</u>	
					20. UNDERTAKER <u>W. G. Puller</u> ADDRESS	

*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.)

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 usefulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or more on the first line will be sufficient, e. g., *Farmer* or *Teacher*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*.

But in many cases, especially in industrial occupations, 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*, (c) *Salesman*, (d) *Grocery*, (e) *Foreman*, (f) *Automobile factory*. The material worked on may form the subject of the second statement. Never return "Miner," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Miner 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*, *Seamstress* 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 *Washer*, *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 may be indicated thus: *Farmer (retired, 6 years)*. For persons who have no occupation whatsoever, 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 accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is epidemic cerebrospinal meningitis); *Diphtheria* (never use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("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 neoplasm); *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.; *Broncho-pneumonia* (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.

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Miller Registration District No. 564-368 File No.
 Township Equality Primary Registration District No. 3758 Registered No.
 City (No.) St. Ward)

2. FULL NAME Geo. W. Cotton
 (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

MEDICAL CERTIFICATE OF DEATH

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

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 3/8/17 E. Man REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-8 1927

17. I HEREBY CERTIFY, That I attended deceased from to 19....., (that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (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?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
 , 19 (Address)

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

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

20. UNDERTAKER ADDRESS
A. O.

SUPPLEMENTARY

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION EXACTLY. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION EXACTLY.

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

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