

1 PLACE OF DEATH

State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 1

County Mississippi

Vote James Bayon Registration District No. 1051

Registered No. 1

Inc. Town Dorena, Mo Primary Registration District No. 5768

City _____ (No. _____ St., _____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Samuel W. Brink

(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 Single
Married
Widowed
or Divorced
(Write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6: DATE OF BIRTH Jan 7 1930
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 5 ds. 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) _____

9 BIRTHPLACE (city or town) Dorena, Mo
(State or country)

PARENTS
10 NAME OF FATHER Willie Brink
11 BIRTHPLACE OF FATHER (city or town) Lebanon
(State or country)
12 MAIDEN NAME OF MOTHER Hattie Warner
13 BIRTHPLACE OF MOTHER (city or town) Lebanon
(State or country)

14 (Informant) John Brink
(Address) Dorena, Mo

15 Filed 1/13 1930 J. Brink Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____ 19____
(Month) (Day) (Year)

17 I HEREBY CERTIFY; That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred on the date stated above at _____ m. The CAUSE OF DEATH* was as follows:

No Dr in attendance
200B
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) 205B
(Duration) _____ yrs. _____ mos. _____ ds.

18 WHERE WAS DISEASE CONTRACTED _____ if not at place of death? _____

19 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) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL City Cemetery DATE OF BURIAL 1/13 1930

20 UNDERTAKER Barrett & Stokes ADDRESS Hickman, Ky

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 years)*. 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 symptom 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 symp-

tomatic), "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**

1-30
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Miss Registration District No. 103-1 File No. 1
Township James Papp Primary Registration District No. 5768 Registered No. 1
City (No.) St. Ward)

2. FULL NAME

Samuel W. Duck
(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 12th 1930

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

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

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

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

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

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)

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

21. WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Frank Plummer, M.D.
. 19 (Address) Charleston Mo

14. INFORMANT (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.

15. FILED 1/13, 1930 J. E. Duck REGISTRAR

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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETELY PRESCRIBED BY LAW

SUPPLEMENTARY

5-1953