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 N. B. - WRITE PLAINLY, WITH OBLIQUE WRITING. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Remisot
 County Holland
 Township Holland Registration District No. 636 File No. 5917
 Inc. Town or City Holland, Mo. Primary Registration District No. 6281 Registered No. _____
 2 FULL NAME John Pallard
 (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.

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR or RACE white 5 Single, Married, Widowed, or Divorced (write the word) Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Don't know

6 DATE OF BIRTH _____ 1 Year
 Month _____ Day _____

7 AGE Years 84 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) _____
 (c) Name of employer _____

9 BIRTHPLACE (city or town) Ill.
 (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 M. B. Slater
 (Address) Holland, Mo.

15 Filed 2/3-1930 Abarrison
27-9-30 Acting Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____ 1930
 Month 2 Day 3 Year

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 1930 to 2/3, 1930
 that I last saw him alive on 2/3, 1930
 and that death occurred, on the date stated above, at 9 a. m.
 The CAUSE OF DEATH was as follows:
 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.)
Flu.

18 Where was disease contracted _____
 If not at place of death? _____

Did an operation precede death? _____ Date of _____
 What operation performed? _____
 Was there an autopsy? _____
 What test confirmed diagnosis? _____

(Signed) J. W. Robins M. D.
2/3 1930 (Address) Steele, Mo.

19. PLACE OF BURIAL, CREMATION, or REMOVAL Robeman Cemetery DATE OF BURIAL 2/4 1930
 20 UNDERTAKER Cobb and Co. ADDRESS Holland, Mo.

Burial or Permit issued by _____ Date of issue _____
 Transit _____

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,"

"Sennie," etc.; "Dropsey," "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 septi-cemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMOCIDAL, 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.—Certificates may 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, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Handwritten notes:
 - m. d. p.
 - m. d. p.
 - m. d. p.
 - m. d. p.