

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.

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

PLACE OF DEATH

County Stone
Township Crand
or
Village _____
or
City Crand (NO. _____) St.: _____ Ward _____

Registration District No. 872 File No. 11800
Primary Registration District No. 472 Registered No. _____

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

FULL NAME William Thomas

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE Single
MARRIED Widowed
WIDOWED
OR DIVORCED
(Write the word) Widowed

DATE OF BIRTH Mar 29, 1918
(Month) (Day) (Year)

AGE 89 yrs. 6 mos. 25 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) North Carolina

NAME OF FATHER Francis Thomas

BIRTHPLACE OF FATHER (City or town, State or foreign country) NC

MAIDEN NAME OF MOTHER Susan Enmon

BIRTHPLACE OF MOTHER (City or town, State or foreign country) NC

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Thomas
(ADDRESS) Crand

Filed Mar-31- 1918 H. L. Kern REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 29, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 1, 1918, to March 29, 1918, that I last saw him alive on March 29, 1918, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:
symptoms of old age
137
1918
142 (Duration) ✓ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) B. W. Vincent M. D.
March 29, 1918 (Address) Crand Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Lean Cemetery DATE OF BURIAL -30- 1918
UNDERTAKER W. E. Hill ADDRESS Crand Mo.

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*, *Compositor*, *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*, *Sar-*

coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)



1 PLACE OF BIRTH

County Stone
 Township Pierce
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

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

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

Registration District No. 842 File No. _____

Primary Registration District No. 4517 Registered No. _____

2 FULL NAME

William F. Thomas

(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 W 5 SINGLE W
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

6 DATE OF BIRTH _____ 1 _____
 (Month) (Day) (Year)

7 AGE _____ If LESS than
 1 day _____ hrs.
 or _____ min.?

8 OCCUPATION
 (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,
 State or foreign country)

10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 (Address) _____

15 Filed Apr 1 - 1918 H. P. Kerr
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 29 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
 _____ 191____ to _____ 191____
 that I last saw him _____ alive on _____ 191____
 and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
old age
Cystitis
Prostatitis
 (Duration) _____ yrs _____ mos. 20 ds.

CONTRIBUTORY (Secondary) _____
 (Duration) 5 yrs _____ mos. _____ ds.
 (Signed) Dr. R. W. Stewart M. D.
May 30, 1918 (Address) Crane Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state
 (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
 or Recent Residents)
 At place of death _____ yrs _____ mos. _____ ds. In the State _____ yrs _____ mos. _____ ds.
 Where was disease contracted if not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____
 20 UNDERTAKER _____ ADDRESS _____

Original file, date _____ 19 _____

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

66711

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Tuberculosis of lungs, meninges, peritonaeum, 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), 29ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)