

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.

| PLACE OF DEATH   |  |  | MISSOURI STATE BOARD OF HEALTH<br>BUREAU OF VITAL STATISTICS<br>CERTIFICATE OF DEATH  |               |                              |
|--|--|--|---|---------------|------------------------------|
| County   | <i>Boone Co</i>  |  | Registration District No.   | <i>71</i>     | File No. <i>15823</i>        |
| Township   | <i>Cedar</i>   |  | Primary Registration District No.   | <i>5110-A</i> | Registered No. <i>12</i>     |
| or   | —  |  | (NO. _____)   | St.: _____    | Ward) _____                  |
| Village  | —  |  | [If death occurred in a hospital or institution, give its NAME instead of street and number]  |               |                              |
| or   | —  |  |   |               |                              |
| City   | —  |  | FULL NAME <i>John L. Cassuth</i>  |               |                              |
| PERSONAL AND STATISTICAL PARTICULARS   |  |  | MEDICAL CERTIFICATE OF DEATH  |               |                              |
| SEX <i>Male</i>  | COLOR OR RACE<br><i>White</i>  | SINGLE<br>MARRIED <i>Married</i><br>WIDOWED<br>OR DIVORCED<br>(Write the word) | DATE OF DEATH <i>June 2</i>   |               |                              |
| DATE OF BIRTH<br><i>1847-2-14</i><br>(Month) (Day) (Year)  |  |  | I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,  |               |                              |
| AGE<br><i>63</i> yrs. <i>3</i> mos. <i>16</i> ds.  |  |  | that I last saw h_____ alive on _____, 191____,   |               |                              |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work <i>Stone Mason</i>               |  |  | and that death occurred, on the date stated above, at _____ m.  |               |                              |
| (b) General nature of industry, business, or establishment in which employed (or employer) _____ |  |  | The CAUSE OF DEATH* was as follows:<br><i>Tuberculosis</i>  |               |                              |
| BIRTHPLACE<br>(City or town, State or foreign country) <i>Pike Co MO</i>                         |  |  | (Duration) <i>2</i> yrs. <i>6</i> mos. <i>2</i> ds.   |               |                              |
| PARENTS  | NAME OF FATHER _____   |  | Contributory _____<br>(SECONDARY)   |               |                              |
|  | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) _____ |  | (Duration) _____ yrs. _____ mos. _____ ds.  |               |                              |
|  | MAIDEN NAME OF MOTHER <i>Miss Jones</i>                                |  | (Signed) <i>W L LaMotte</i> M. D.<br><i>June 16 1910</i> (Address) <i>Ashland</i>   |               |                              |
|  | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) _____ |  | *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. |               |                              |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  |  |  | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  |               |                              |
| (Informant) <i>W L LaMotte</i>   |  |  | At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.  |               |                              |
| (ADDRESS) <i>Ashland MO</i>  |  |  | Where was disease contracted if not at place of death? _____  |               |                              |
| Filed <i>June 10 1910</i> <i>W L LaMotte</i> REGISTRAR   |  |  | Former or usual residence _____   |               |                              |
|  |  |  | PLACE OF BURIAL OR REMOVAL _____  |               | DATE OF BURIAL _____ 191____ |
|  |  |  | UNDERTAKER _____  |               | ADDRESS _____                |

# 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 septichaemia," "PUERPERAL peritonitis," etc. State cause for which surgi al 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.)

