

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 Caldwell
 Township X
 or
 Village Coalgate
 or
 City X

Registration District No. 95 File No. 33480
 Primary Registration District No. 4057 Registered No. 10
 (NO. _____ St. _____ Ward)

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

FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS			
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <i>(Write the word)</i> <u>X</u>	
DATE OF BIRTH <u>Nov 3, 1910</u> (Month) (Day) (Year)			
AGE <u>X</u> yrs. <u>X</u> mos. <u>X</u> ds.	If LESS than 1 day, <u>X</u> hrs. or <u> </u> min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>			

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Nov 3, 1910</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Nov 3, 1910</u> , to <u>Nov 3, 1910</u> , that I last saw him alive on <u>Stillborn</u> , 1910, and that death occurred, on the date stated above, at <u>Nov</u> m. The CAUSE OF DEATH* was as follows: <u>Still Born</u> <u>NO CODE</u>	
(Duration) _____ yrs. _____ mos. _____ ds.	

BIRTHPLACE (City or town, State or foreign country)	
<u>Coalgate Mo</u>	
PARENTS	
NAME OF FATHER <u>Geo W Crawford</u>	
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
MAIDEN NAME OF MOTHER <u>Ella Barbara</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

Contributory (SECONDARY)	(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____	M. D.
	1910 (Address) _____

*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 _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Crawford
 (ADDRESS) Coalgate Mo

Filed Nov 3, 1910 R D Smith
 REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Coalgate</u>	DATE OF BURIAL <u>Nov 3, 1910</u>
UNDERTAKER <u>B M Hooks</u>	ADDRESS <u>Coalgate Mo</u>

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.)



REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

PLACE OF DEATH Caldwell
County _____
Township _____
or _____
Village Cowgill
or _____
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 95 File No. 33480
Primary Registration District No. 4057 Registered No. 11

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

FULL NAME Unnamed Crawford

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____
SINGLE MARRIED WIDOWED OR DIVORCED
(Write the word)

DATE OF DEATH Nov 3, 1910
(Month) (Day) (Year)

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

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 191____,

AGE _____ yrs. _____ mos. _____ ds.
If LESS than 1 day, _____ hrs. or _____ min.?

that I last saw _____ alive on _____, 191____,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH was as follows:

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

Still Born

BIRTHPLACE (City or town, State or foreign country) _____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

PARENTS NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER _____
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

(Signed) J D Smith M. D.
Nov 3 1910 (Address) Cowgill 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL Cowgill Mo DATE OF BURIAL Nov 3 1910

Filed Nov 3 1910 J D Smith REGISTRAR

UNDERTAKER B M Hicks ADDRESS Cowgill

SUPPLEMENTARY

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

N. B. Every item of information secured by certificate reported hereon is printed upon printed forms prepared by the Missouri State Board of Health. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Revised United States Standard Certificate of Death

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

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