

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

PLACE OF DEATH

County Carroll
Township Stokes Mound
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 139
Primary Registration District No. 5799

File No. 37321
Registered No. 16

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

FULL NAME Everett Lewis

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>Single</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Jan.</u> <u>76</u> , 18 <u>83</u> (Month) (Day) (Year)		
AGE <u>27</u> yrs. <u>0</u> mos. <u>0</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		

BIRTHPLACE (City or town, State or foreign country) <u>Luningston Co.</u>	
PARENTS	NAME OF FATHER <u>Reuben Lewis</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Carroll Co.</u>
	MAIDEN NAME OF MOTHER <u>Liza Johnson</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio Alliance</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Reuben Lewis
Hale Mo
(ADDRESS)

Filed Dec 10, 1910, O.R. Edmonds
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 26, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 24, 1910, to Nov 26, 1910, that I last saw him alive on Nov 26, 1910, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W.P. Kunk M. D.
Nov 26, 1910 (Address) Hale 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 Buried, Excelsior DATE OF BURIAL Nov 26, 1910
UNDERTAKER J.E. Gates ADDRESS _____

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.

MARGIN RESERVED FOR BINDING

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, peritonaeum*, 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.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MISSOURI STATE BOARD OF HEALTH

PLACE OF DEATH _____
 County Barroll
 Townshp Stoker mound
 or _____
 Village _____
 or _____
 City _____ (NO. _____) St. _____ Ward _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Registration District No. 139 File No. 37321
 Primary Registration District No. 5199 Registered No. 16

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

FULL NAME Everart Lewis

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M.</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <i>(Write the word)</i> <u>Single</u>	DATE OF DEATH _____, _____, 191 <u>0</u> <i>(Month) (Day) (Year)</i>	
DATE OF BIRTH _____, _____, 18 <u>83</u> <i>(Month) (Day) (Year)</i>			I HEREBY CERTIFY, that I attended deceased from _____, 191 <u>0</u> , to _____, 191 <u>0</u> , that I last saw _____ alive on _____, 191 <u>0</u> , and that death occurred, on the date stated above, at _____ m.	
AGE <u>27</u> yrs. _____ mos. _____ ds.			If LESS than 1 day, _____ hrs. or _____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			The CAUSE OF DEATH* was as follows: <u>Diphtheria</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Lurungston Ga.</u>			(Duration) _____ yrs. _____ mos. <u>3</u> ds.	
PARENTS	NAME OF FATHER <u>Reuben Lewis</u>		Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Barroll, Mo.</u>		(Signed) <u>W. G. Kamp</u> M. D. <u>11/26</u> 191 <u>0</u> (Address) <u>Hale, Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Liza Johnson</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>St. Albans, Vt.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Reuben Lewis</u> (ADDRESS) <u>Hale, Mo.</u> Where was disease contracted If not at place of death? _____ Former or usual residence _____				
Filed <u>Dec 10</u> 191 <u>0</u> <u>O. R. Edmonds</u> REGISTRAR.			PLACE OF BURIAL OR REMOVAL <u>Burned Lewis St. 11/26</u> 191 <u>0</u> DATE OF BURIAL _____, _____, 191 <u>0</u> UNDERTAKER <u>E. Stater</u> ADDRESS <u>Hale, Mo.</u>	

DEC

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]

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