

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
 County Knox
 Township Salt River
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward)

 170
 Registration District No. 446 File No. 2135
 Primary Registration District No. 5606 Registered No. 1

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

 FULL NAME Walter Edward Keuling

PERSONAL AND STATISTICAL PARTICULARS

 SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

 DATE OF BIRTH Feb 27, 1872
 (Month) (Day) (Year)

 AGE 38 yrs. 10 mos. 18 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) Knox Co Mo

 PARENTS
 NAME OF FATHER Samuel Keuling
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Rhode Island
 MAIDEN NAME OF MOTHER Susan Johnson
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) W. Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) C.S. Keuling
 (ADDRESS) Novelt, Mo.

 Filed Jan 27, 1911 J. A. McWilliams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 DATE OF DEATH Jan 18, 1911
 (Month) (Day) (Year)

 I HEREBY CERTIFY, that I attended deceased from Jan 18-9 AM, 1911, to Jan 18-10 PM, 1911, that I last saw him alive on Jan 18, 1911, and that death occurred, on the date stated above, at 10 P.M. The CAUSE OF DEATH* was as follows:

Uremia
132B

 (Duration) ____ yrs. ____ mos. 1 ds.

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

(Signed) _____ (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 _____

 PLACE OF BURIAL OR REMOVAL Laurel Hill DATE OF BURIAL Jan 22, 1911

 UNDERTAKER D. S. Christie ADDRESS La Plata 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*, *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*, *peritonacum*, 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.)



PLACE OF DEATH

County Knox
 Township Sale River
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

MISSOURI STATE BOARD OF HEALTH
 REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 446- File No. 2135-
 Primary Registration District No. 3606 Registered No. _____

FULL NAME Walter Edw. Heuling

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH 2-27- 1872
(Month) (Day) (Year)

AGE 28 yrs. 10 mos. 18 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) Knox Co. Mo.

PARENTS
 NAME OF FATHER Saml Heuling
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Phad
 MAIDEN NAME OF MOTHER Susan Johnson
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) W. Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.S. Heuling
 (ADDRESS) Novelty Mo

Filed Jan 24 1911 J. A. McWilliam REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ 1-18, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1-18, 1911, to 1-18, 1911, that I last saw He alive on 1-18, 1911, and that death occurred, on the date stated above, at 10 p. m. The CAUSE OF DEATH* was as follows:

Heart Disease

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

(Signed) J. M. Humphreys M. D. Mar 8 1911 (Address) Healdsburg 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 Sound Hill DATE OF BURIAL 1-22 1911

UNDERTAKER D. L. Christen ADDRESS La Plata Mo

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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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.)