

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Ray
Township Washington
or
Village
or
City

Registration District No. 743
Primary Registration District No. 6237

File No. 7602
Registered No.

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

FULL NAME

Wm Duncan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE Single
MARRIED WIDOWED OR DIVORCED
(If married, give name)
DATE OF BIRTH July 8 1909
(Month) (Day) (Year)
AGE 1 4 16
If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Nov 24 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 18 1910, to Nov 24 1910, that I last saw him alive on Nov 24 1910, and that death occurred, on the date stated above, at 9:20 p.m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

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

BIRTHPLACE (City or town, State or foreign country) Ray County

Contributory Lobar Pneumonia
(Duration) yrs. mos. ds.

NAME OF FATHER J. B. Duncan

(Duration) yrs. mos. ds.
Contributory Lobar Pneumonia

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ray Co.

(Duration) yrs. mos. ds.
Signed H. J. Clark M. D.

MAIDEN NAME OF MOTHER Minna Brown

(Address) Walcott Spgs.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ray Co.

*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) Wm Duncan

At place of death 1 yrs 4 mos 16 ds In the State 4 mos 16 ds

(ADDRESS) Walcott Spgs. Mo.

Where was disease contracted if not at place of death? Unknown

Filed 2-6-11 REGISTRAR

Former or usual residence Walcott Spgs.

PLACE OF BURIAL OR REMOVAL Walcott Spgs. Mo.

DATE OF BURIAL Nov 25 1910

UNDETAILED ADDRESS Walcott Spgs.

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.)



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

PLACE OF DEATH *not stated*

County *Ray*
Township *Section 9 River*
Village _____
City *Excelsior Spgs.* (NO. _____ St.; _____ Ward)

Registration District No. *743 -*
Primary Registration District No. *6237*
File No. *7662*
Registered No. *116*

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

FULL NAME *Eva Sincan*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *Female* COLOR OR RACE *White* SINGLE MARRIED WIDOWED OR DIVORCED *Single*
(If write the word)

DATE OF DEATH *Nov 24*, 1910
(Month) (Day) (Year)

DATE OF BIRTH *July 8*, 1899
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Nov 18*, 1910, to *Nov 24*, 1910, that I last saw him live on *Nov 24*, 1910, and that death occurred, on the date stated above, at *9:20 p.m.*

AGE *1* yrs. *4* mos. *14* ds.
If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Acute meningitis

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

BIRTHPLACE (City or town, State or foreign country) *Ray County*

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory *Labor Pneumonia*
(SECONDARY)

PARENTS NAME OF FATHER *J B Sincan*
BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ray Co.*
MAIDEN NAME OF MOTHER *Mahinda Rose*
BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ray Co.*

(Signed) *H. J. Clark* M. D.
Nov. 25, 1910. (Address) *Excelsior Spgs.*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Willie Sincan*
(ADDRESS) *Excelsior Spgs 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, *1* yrs. *4* mos. *16* ds. In the State *1* yrs. *4* mos. *16* ds.
Where was disease contracted if not at place of death? *Unknown*
Former or usual residence *Excelsior Spgs.*

Filed *Nov. 25*, 1910. *T. B. Bogart*
REGISTRAR

PLACE OF BURIAL OR REMOVAL *Odell Graveyard* DATE OF BURIAL *Nov. 25, 1910*
UNDERTAKER *E. E. Coulter* ADDRESS *Excelsior Spgs Mo*

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Association]

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