

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.

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

PLACE OF DEATH  
County Wright  
Township Montgomery  
or Village  
or City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

61  
Registration District No. 911 File No. 9233  
Primary Registration District No. 6227 Registered No. 3

FULL NAME George Monte Todd

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)  
DATE OF BIRTH Jan 27, 1911  
(Month) (Day) (Year)  
AGE 1 yrs. 2 mos. 2 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) None

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 29, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 14, 1911, to Jan 29, 1911, (that I last saw him alive on Jan 27, 1911, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH\* was as follows:  
Cerebrospinal Meningitis  
77B

(Duration) \_\_\_ yrs. \_\_\_ mos. 15 ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) A. L. Anthony M. D.  
Jan 30, 1911 (Address) Psychburg 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  DATE OF BURIAL \_\_\_\_\_, 1911

UNDERTAKER  ADDRESS \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Mingsville Mo.

NAME OF FATHER Wm Henry Todd

BIRTHPLACE OF FATHER (City or town, State or foreign country) Wright Co Mo

MAIDEN NAME OF MOTHER Maud M. Rader

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wright Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Henry Todd  
(ADDRESS) Mingsville Mo

Filed ✓, 1911

REGISTRAR

# 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, 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.)



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important terms.

PLACE OF DEATH

County Lehigh  
Township Montgomery  
or  
Village  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH  
Registration District No. 911- File No. 9233  
Primary Registration District No. 6227- Registered No. \_\_\_\_\_

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

FULL NAME Geo. Monte Todd

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M.</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>1-27-</u> <u>911</u> (Month) (Day) (Year)		
AGE <u>1</u> yrs. <u>X</u> mos. <u>2</u> ds.		IF LESS than 1 day, _____ hrs. or _____ 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)		

BIRTHPLACE (City or town, State or foreign country) <u>Marysville Wis</u>	
PARENTS	NAME OF FATHER <u>Wm Henry Todd</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Lehigh Pa</u>
	MAIDEN NAME OF MOTHER <u>Mary Ann Rader</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Lehigh Pa</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Henry Todd

(ADDRESS) Springfield Pa

Filed Feb 4 1911 Geo R Rader REGISTRAR

original file data

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH \_\_\_\_\_ 1-29-1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 1-14- to 1-29, 1911, that I last saw him alive on 1-27, 1911, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH\* was as follows:  
Chorea Special meningitis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 15 ds.

Contributory \_\_\_\_\_

(SECONDARY) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) A. L. Anthony M. D.  
1-24 1911 (Address) Lynchburg

\*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 <u>Marion Cemetery</u>	DATE OF BURIAL <u>Feb 30</u> 191 <u>1</u>
UNDERTAKER <u>None</u>	ADDRESS <u>X</u>

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.)