

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

70 16

County Douglas

Township Benton

Village _____

City Concord (NO. _____)

Registration District No. 272

File No. 20780

Primary Registration District No. 1379

Registered No. _____

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

FULL NAME John Collins

PERSONAL AND STATISTICAL PARTICULARS

SEX MR COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Wid
(If wife the word)

DATE OF BIRTH May 12 1877
(Month) (Day) (Year)

AGE 39 yrs. - mos. - ds. IF LESS than 1 day, - hrs. or - min.?

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

BIRTHPLACE (City or town, State or foreign country) Mo 3-67

PARENTS
NAME OF FATHER W. Collins
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Staley

(ADDRESS) Ledale Mo

Filed June 12 1911 W. H. Osborn
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 8 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911, that I last saw alive on _____, 1911, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Cis. Per City
Carbolic Poison
(Duration) 10 yrs. - mos. - ds.

Contributory None
(SECONDARY) (Duration) - yrs. - mos. - ds.
(Signed) Prof Stewart Per City
1911 (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 Lead Mo DATE OF BURIAL unknown 1911

UNDERTAKER W. Staley ADDRESS Ledale 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*, *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.)



Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHPLACE OF DEATH
County Douglas
Township Barton
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)Registration District No. 277 File No. 20780
Primary Registration District No. 5379 Registered No. _____

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

FULL NAME Wm Collins

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If rate the word)
DATE OF BIRTH _____, 191____ (Month) (Day) (Year)		
AGE _____, yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Common Laborer(b) General nature of industry, business, or establishment in which employed (or employer) none

BIRTHPLACE

(City or town, State or foreign country)

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
_____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

_____, to _____, 191____,

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

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

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Pneumonia
Common Laborer, Suicidal
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

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

(Signed) Had none M. D._____, 191____ (Address) 1174 Osborn

*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

UNDERTAKER

ADDRESS

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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