

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 Jackson
Township Blue
or
Village
or
City Independence (NO. _____ St. _____ Ward _____)

Registration District No. 395 File No. 21076
Primary Registration District No. 5554 Registered No. 132

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

FULL NAME John Stanley

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Dec 26, 1909
(Month) (Day) (Year)

AGE 1 yrs. 6 mos. X ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Arkansas

PARENTS
NAME OF FATHER Charlie Stanley
BIRTHPLACE OF FATHER (City or town, State or foreign country) Egypt
MAIDEN NAME OF MOTHER Annie Stanley
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Egypt

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Stanley
(ADDRESS) Egypt

Filed June 5 1911 L. E. Kimminger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 26, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 25th, 1911, to May 26th, 1911, that I last saw him alive on May 25th, 1911, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Pneumonia

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

Contributory Bowel trouble
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. S. Thomas M. D.
(Address) 1181 Grand Ave

*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 Independence DATE OF BURIAL 7/26, 1911
UNDERTAKER Geo. Brown & Son ADDRESS Independence
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, 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.)



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

County Jackson
Township Blue
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 398 File No. 21076
Primary Registration District No. 5554 Registered No. 132

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

FULL NAME

John Stanley

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Dec. 26, 1909
(Month) (Day) (Year)
AGE 1 yrs. 6 mos. ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Arkansas

PARENTS

NAME OF FATHER Charley Stanley
BIRTHPLACE OF FATHER (City or town, State or foreign country) Egypt
MAIDEN NAME OF MOTHER Annie Stanley cousin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Egypt

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Stanley
(ADDRESS) Egypt

Filed June 5, 1911 C. E. Krimminger
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 26, 1911
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from May 25, 1911, to May 26, 1911, that I last saw him alive on May 25, 1911, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Bowel trouble
(SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Wm. S. Thomas M. D.
May 27, 1911 (Address) 1131 Grand Ave.

*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. State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Independence DATE OF BURIAL 5/26, 1911
UNDERTAKER Geo. Bowers + Son Independence Bowers ADDRESS _____

Original file, date _____ 19 _____

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.)