

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

PLACE OF DEATH

County Lawrence
Township Ogark
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 474 File No. 21637
Primary Registration District No. 5638 Registered No. 1914

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

FULL NAME Earl Fine

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH December 30, 1910
(Month) (Day) (Year)

AGE _____ yrs. 5 mos. 17 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) _____

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

PARENTS
NAME OF FATHER Benjamin Fine
BIRTHPLACE OF FATHER (City or town, State or foreign country) Lawrence Co Mo.
MAIDEN NAME OF MOTHER Essie Mynatt
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lawrence Co Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Bertin
(ADDRESS) Halltown Mo

Filed ✓ 1911 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 16, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 31, 1911, to June 16, 1911, that I last saw him alive on June 16, 1911, and that death occurred, on the date stated above, at 5:55^{PM} m.

The CAUSE OF DEATH* was as follows:

9 Pertussis
1069C 04
(Duration) _____ yrs. 1 mos. 14 ds.

Contributory Bronchitis
(SECONDARY) (Duration) _____ yrs. 1 mos. _____ ds.

(Signed) S. M. Clark M. D.
June 17, 1911 (Address) Halltown 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 Halltown Mo DATE OF BURIAL 6-17, 1911

UNDERTAKER Will Benton ADDRESS Halltown Mo.

No. 1. 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.

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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County LawrenceTownship Ozark

Village _____

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 474 File No. 21637Primary Registration District No. 5638 Registered No. 9

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

FULL NAME

Earl Finic

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) singleDATE OF BIRTH Dec. 30, 1910
(Month) (Day) (Year)AGE 5 yrs. 17 mos. 17 ds. IF LESS than 1 day, ___ hrs. or ___ min. 7OCCUPATION (a) Trade, profession, or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer) _____BIRTHPLACE (City or town, State or foreign country) Springfield Mo.NAME OF FATHER Benjamin FinicBIRTHPLACE OF FATHER (City or town, State or foreign country) Lawrence Co. Mo.MAIDEN NAME OF MOTHER Elsie MynattBIRTHPLACE OF MOTHER (City or town, State or foreign country) Lawrence Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Burton(ADDRESS) Halltown Mo.Filed 8-15 1911 Leonia J. Gunn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 16, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from May 31, 1911, to June 16, 1911, that I last saw him alive on June 16, 1911, and that death occurred, on the date stated above, at 5:55 P.M.The CAUSE OF DEATH[†] was as follows:Pertussis(Duration) yrs. 1 mos. 14 ds.Contributory Bronchitis
(SECONDARY)(Duration) yrs. 1 mos. ds.(Signed) S. M. Clark M. D.June 17, 1911 (Address) Halltown Mo.

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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 Halltown Mo.DATE OF BURIAL 6-17, 1911UNDERTAKER Wm. Burton Halltown Mo.

ADDRESS _____

Original file, date 6-17, 1911. All information called for must be written on this Supplemental Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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