

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 Phelps
Township _____
or
Village _____
or
City Newburg Mo. (NO. _____) St.: _____ Ward _____

Registration District No. 676 File No. 29117
~~4402~~
Primary Registration District No. 676 Registered No. 23
~~4402~~

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

FULL NAME George Allan Congest

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH June 25, 1911
(Month) (Day) (Year)

AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
yrs. 1 mos. 10 ds.

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

BIRTHPLACE (City or town, State or foreign country) Newburg Mo

PARENTS
NAME OF FATHER Allan Congest
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind. Ind.
MAIDEN NAME OF MOTHER Ethel Osborn
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Newburg Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethel Osborn
(ADDRESS) Newburg Mo

Filed 8/4 1911 B.T. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 4, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 2, 1911, to Aug 3, 1911, that I last saw him alive on Aug 13, 1911, and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows:
Infective Spasms
St. 7

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

(Signed) B.T. Smith M. D.
874 1911 (Address) Newburg 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 Newburg Cemetery DATE OF BURIAL 8/5 1911

UNDERTAKER F. Spradling ADDRESS Newburg 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*, *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, 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.)



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



PLACE OF DEATH

County Chillico

Township _____

Village _____

City Newburg, Mo. (NO. _____)

Registration District No. 676

File No. _____

Primary Registration District No. 4402

Registered No. 23

St.: _____ Ward _____

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

FULL NAME Geo. Allan Conquest

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED S (Write the word)

DATE OF DEATH 8 - 4, 1911
(Month) (Day) (Year)

DATE OF BIRTH June 25, 1911
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1911, to 8-3, 1911, that I last saw him alive on 8-3, 1911

AGE 1 yrs. 10 mos. 10 ds. If LESS than 1 day, _____ hrs. or _____ min.?

and that death occurred, on the date stated above, at 4:45 m.

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

The CAUSE OF DEATH* was as follows:
Convulsions

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

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

NAME OF FATHER Geo. W. Osborne

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark. Ter.

(Signed) B. P. Smith M. D. 8-4, 1911 (Address) Newburg, Mo.

MAIDEN NAME OF MOTHER W. Osborne

*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Newburg, Mo.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Geo. W. Osborne

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) Newburg, Mo.

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

Filed 8 X 1911 B. P. Smith REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Newburg Cem. DATE OF BURIAL 8-5, 1911

UNDERTAKER Exbradling ADDRESS Newburg, Mo.

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.)

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