

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

PLACE OF DEATH

County Washington
Township Rickwoods
or
Village
or
City (NO. _____) St. _____ Ward _____

Registration District No. 889 File No. 30500
Primary Registration District No. 6/85 Registered No. 19

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

FULL NAME Louis Sylvester Delcour

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED married WIDOWED OR DIVORCED (If rit's the word)
DATE OF BIRTH Jan 19 1866 (Month) (Day) (Year)
AGE 43 yrs. 6 mos. 25 ds. If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Fanner
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

DATE OF DEATH Aug 14 1911 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from June 1, 1911, to Aug 14, 1911, that I last saw him alive on Aug 14, 1911, and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
234 Tuberculosis

BIRTHPLACE (City or town, State or foreign country) Rickwoods mo

(Duration) 00 yrs. ____ mos. ____ ds.
Contributory (SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

PARENTS
NAME OF FATHER Gonip Delcour
BIRTHPLACE OF FATHER (City or town, State or foreign country) Rickwoods
MAIDEN NAME OF MOTHER Margaret Alexander
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rickwoods mo

(Signed) David Ford M. D.
Aug 15 1911 (Address) Rickwoods
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. U. Delcour
(ADDRESS) Rickwoods mo

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 _____

Filed Aug 24 1911
C. J. Ryan mo REGISTRAR

PLACE OF BURIAL OR REMOVAL Catholic cemetery DATE OF BURIAL Aug 16 1911
UNDERTAKER ADDRESS _____

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.

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St.: _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____

COLOR OR RACE _____

SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (Write the word)

DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

AGE _____

IF LESS than
 1 day, _____ hrs.
 or _____ min.?

_____ mos. _____ ds.

OCCUPATION _____

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

BIRTHPLACE _____

(City or town, State or foreign country)

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 _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

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

The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY)

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

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

M. D. _____

(Address) _____, 191____

*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 _____ 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 _____

191____

7. 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.

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

PLACE OF DEATH

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

County Washington
Township Richwoods
or
Village
or
City

Registration District No. 589 File No.
Primary Registration District No. 6185- Registered No. 19
(NO. St. Ward)

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

FULL NAME Louis Sylvester Delcours

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 14, 1911
(Month) (Day) (Year)

DATE OF BIRTH Jun 19, 1866
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 1, 1911, to Aug 14, 1911, that I last saw him alive on Aug 14, 1911

AGE 45 yrs. 6 mos. 25 ds. IF LESS than 1 day, hrs. or mins.

and that death occurred, on the date stated above, at 10 P.M.

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

The CAUSE OF DEATH* was as follows:
Tuberculosis

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

(Duration) 1 yrs. mos. ds.

PARENTS NAME OF FATHER Louis D. Delcours BIRTHPLACE OF FATHER Richwoods MAIDEN NAME OF MOTHER Margaret Alexander BIRTHPLACE OF MOTHER Richwoods Mo.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) David Ford M. D. (Address) Richwoods Aug 15, 1911

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) L. N. Delcours (ADDRESS) Richwoods, 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

Filed Aug 14 1911 E. J. Phyness REGISTRAR

PLACE OF BURIAL OR REMOVAL Catholic Cem DATE OF BURIAL Aug 16, 1911 UNDERTAKER M. V. Flynn ADDRESS Richwoods

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 *Dry 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.)

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