

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH **30502A**

PLACE OF DEATH

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

Registration District No. 1080 File No. 24287A
Primary Registration District No. 6180 Registered No. 18

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

FULL NAME

Earl Page

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 Aug. 14, 1911
(Month) (Day) (Year)

DATE OF BIRTH Aug. 7, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from never, 1911, to _____, 1911, that I last saw h_____ alive on _____, 1911,

AGE _____ yrs. _____ mos. 7 ds. If LESS than 1 day, _____ hrs. or _____ min.?

and that death occurred, on the date stated above, at 6 a.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:
No physicians
159 151

BIRTHPLACE (City or town, State or foreign country) This Co.

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

NAME OF FATHER Earl Page

Contributory Premature Birth
(SECONDARY)

BIRTHPLACE OF FATHER (City or town, State or foreign country) This Co. S

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

MAIDEN NAME OF MOTHER Ava McEwen

(Signed) S. J. Thurman M. D.
Aug. 23, 1911 (Address) Potosi Mo

BIRTHPLACE OF MOTHER (City or town, State or foreign country) This Co.

*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) Louis S. Page

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

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

(ADDRESS) Floyd Mo.

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

Former or usual residence _____

Filed Aug. 23, 1911 J. H. Hery REGISTRAR

PLACE OF BURIAL OR REMOVAL Last Creek, this Co. DATE OF BURIAL Aug. 14, 1911

UNDERTAKER None ADDRESS None

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.

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 c. es, 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.)



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PLACE OF DEATH
County Washington
Township Wallon
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 887 File No. _____
Primary Registration District No. 4180 Registered No. 8

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

FULL NAME Carl Page

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH Aug. 7, 1911
(Month) (Day) (Year)

AGE 0 yrs. 0 mos. 7 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) none

BIRTHPLACE
(City or town, State or foreign country) This Co.

PARENTS
NAME OF FATHER Carl Page
BIRTHPLACE OF FATHER (City or town, State or foreign country) This Co.
MAIDEN NAME OF MOTHER Ava McEwen
BIRTHPLACE OF MOTHER (City or town, State or foreign country) This Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis A Page
(ADDRESS) Floyd Mo

Filed Aug 13, 1911 J. F. Thurman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from nevr, 1911, to _____, 1911, that I last saw him alive on _____, 1911, and that death occurred, on the date stated above, at 6:15 m. The CAUSE OF DEATH was as follows:

Physician
Contributory Permaturo Birth
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) St. Thurman M. D.
Aug 13, 1911 (Address) Potosi 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 Lost creek, this Co. DATE OF BURIAL Aug. 14, 1911
UNDERTAKER none ADDRESS none

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.

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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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