

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

Registration District No. *123* File No. *30896*
Primary Registration District No. *5205* Registered No. _____

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

FULL NAME *Daniel Joseph Nichols*

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* COLOR OR RACE *White* SINGLE *single* MARRIED WIDOWED OR DIVORCED, (If write the word)

DATE OF BIRTH *Dec 21 1889*
(Month) (Day) (Year)

AGE *21* yrs. *8* mos. *22* ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work *Laborer. S. & B.*
(b) General nature of industry, business, or establishment in which employed (or employer) *Log Driving on river*

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

PARENTS
NAME OF FATHER *Joseph Nichols*
BIRTHPLACE OF FATHER (City or town, State or foreign country) *Mo.*
MAIDEN NAME OF MOTHER *Jessie Hoover*
BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ohio*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *D. J. Nichols*

(ADDRESS) _____

Filed *Sep 13 1911* *M. Cotton*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Sep 12 1911*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *12:20 am Sep 12*, 1911, to *11 P.M. Sep 12*, 1911, that I last saw him alive on *Sep 12*, 1911, and that death occurred, on the date stated above, at *11 P.M.*

The CAUSE OF DEATH* was as follows:
Peniculous malarial

15 B (Duration) *9* yrs. *2* mos. *ds.*

Contributory *Cigarette Smoking*
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) *M. Cotton* M. D.
Sep 13 1911 (Address) *Van Buren*

*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 *Van Buren Cemetery* DATE OF BURIAL *Sep 13 1911*

UNDERTAKER ADDRESS *Van Buren, 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.

Association, as mine, etc. ties of the receive a fe, House-employed, ken to re-
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.)



County Walter
 Township Carter
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward)

Registration District No. 143 File No. _____
 Primary Registration District No. 5205 Registered No. _____

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

FULL NAME David Joseph Nichols

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED single
 (Write the word)
 DATE OF BIRTH 12-21-1879
 (Month) (Day) (Year)
 AGE 21 yrs. 8 mos. 22 ds.
 If LESS than 1 day, hrs. or mins.
 OCCUPATION (a) Trade, profession, or particular kind of work laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) dry cleaning

DATE OF DEATH 9-12-1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from 9-12-1911, to 9-12-1911,
 that I last saw her alive on 9-12-1911,
 and that death occurred, on the date stated above, at 11 P.M.

BIRTHPLACE (City or town, State or foreign country) Mo
 NAME OF FATHER Joseph Nichols
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
 MAIDEN NAME OF MOTHER Janet Hooper
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

The CAUSE OF DEATH* was as follows:
Pericious Malaria
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Cigarette Smoking
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) J. W. Cotton M. D.
9-13-1911 (Address) Van Buren

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) D. J. Nichols

*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 _____

(ADDRESS) Van Buren, Mo.
 Filed 9/13/1911 J. W. Cotton
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Van Buren, Mo. DATE OF BURIAL 9-13-1911
 UNDERTAKER J. N. Rose ADDRESS Van Buren

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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