

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

PLACE OF DEATH

County Lafayette
Township Gallatin
or
Village None
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 197 File No. 34029
Primary Registration District No. 5276 Registered No. 32

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

FULL NAME Wilber N Howell

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
DATE OF BIRTH July 9, 1911
(Month) (Day) (Year)
AGE 2 yrs. 2 mos. 15 ds. if LESS than
1 day, ___ hrs. or ___ min.?

DATE OF DEATH Oct 24, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 20, 1911, to Oct 24, 1911, that I last saw him alive on Oct 24, 1911, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
194B General Inanition

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) Harlem

PARENTS
NAME OF FATHER Colorene Howell
BIRTHPLACE OF FATHER Lafayette Co
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Nelly Johnson
BIRTHPLACE OF MOTHER Lafayette Co
(City or town, State or foreign country)

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory none
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. M. Dagg M. D.
Nov 9, 1911 (Address) Harlem

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Dagg
(ADDRESS) Harlem

Where was disease contracted if not at place of death?
Former or usual residence _____

Filed 10/25, 1911 W. J. Ward REGISTRAR

PLACE OF BURIAL OR REMOVAL Oak Crest Cemetery DATE OF BURIAL Oct 26, 1911
UNDERTAKER none 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 (<i>Write the word</i>)
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DATE OF BIRTH

..... (Month) 191..... (Day), 1..... (Year)

AGE

..... yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

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) 191..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to....., 191.....,

that I last saw h..... alive on.....

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

The CAUSE OF DEATH* was as follows:

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

Contributory

(SECONDARY)

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

(Signed)..... 191..... (Address)..... M. D.

*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

DATE OF BURIAL

191.....

UNDERTAKER

ADDRESS

County Clay Registration District No. 197 File No. _____
 or _____
 Township Gallatin Primary Registration District No. 5276 Registered No. 32
 or _____
 Village _____
 or _____
 City _____ No. _____ St. _____ Ward _____

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

FULL NAME Wilber N. Howell

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE 1 MARRIED 1 WIDOWED 1 OR DIVORCED 1
 (Write the word)

DATE OF BIRTH July 9, 1911
 (Month) (Day) (Year)

AGE 2 yrs. 15 mos. 15 ds. IF LESS than 1 day, hrs. or mins.

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) Harlem, N.Y.

PARENTS
 NAME OF FATHER Clarence Howell
 BIRTHPLACE OF FATHER Clay Co.
 MAIDEN NAME OF MOTHER Mrs. Johnson
 BIRTHPLACE OF MOTHER Clay Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Bagg
 (ADDRESS) Harlem

Filed 12/23/11, 1911 J. Grand REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 24, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 24, 1911, to Oct 24, 1911, that I last saw him alive on Oct 24, 1911, and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH was as follows:
General Inanition
Want of proper care and food
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY)
None (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) A. M. Bagg M. D.
Nov 9, 1911 (Address) Harlem

*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 Carl West Cem DATE OF BURIAL Oct 26, 1911

UNDERTAKER none ADDRESS _____

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.)

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