

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 Greene

Township \_\_\_\_\_

Village \_\_\_\_\_

City Springfield Mo.

Registration District No. 318

File No. 34405

Primary Registration District No. 2001

Registered No. 643

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Alfred J. Vinney

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

DATE OF DEATH 10 - 29, 1911  
(Month) (Day) (Year)

DATE OF BIRTH April 1, 1883  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 10-26-11, 1911, to 10-29, 1911 that I last saw him alive on 10-29, 1911, and that death occurred, on the date stated above, at 8 P. M.

AGE 28 yrs. 6 mos. 29 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

THE CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work R-R Employee  
(b) General nature of industry, business, or establishment in which employed (or employer) Section Hand

Fractured spine (cervical region)  
207M 175  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

BIRTHPLACE (City or town, State or foreign country) Wisconsin

Contributory (SECONDARY) Exhaustion  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

NAME OF FATHER Emily Vinney

(Signed) M. H. Hogeworn M. D.  
10/30, 1911 (Address) Springfield Mo

BIRTHPLACE OF FATHER (City or town, State or foreign country) France

MAIDEN NAME OF MOTHER Sophia Berge

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

\*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

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 \_\_\_\_\_

(Informant) Mary Ward

(ADDRESS) Metropolitan Hotel

PLACE OF BURIAL OR REMOVAL Perona Mo. DATE OF BURIAL Oct. 31, 1911

Filed 10-30, 1911 213 REGISTRAR

UNDERTAKER Coxson and Co ADDRESS 1110. South

# 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.)



## PLACE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_

or  
Village \_\_\_\_\_or  
City Springfield (NO. \_\_\_\_\_)REGISTRARS SHALL NOT RE-  
CEIVE A FEE FOR CERTIFICATES  
UNTIL THEY ARE COMPLETED AS  
PRESCRIBED BY LAW.MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Registration District No. \_\_\_\_\_

File No. 34405Primary Registration District No. 2001

Registered No. \_\_\_\_\_

St.: \_\_\_\_\_ Ward) \_\_\_\_\_

(If death occurred in a  
hospital or institution,  
give its NAME instead  
of street and number)FULL NAME Alfred T. Wiley

## PERSONAL AND STATISTICAL PARTICULARS

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_ SINGLE  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)DATE OF BIRTH \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Month) (Day) (Year)AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than  
1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ 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 \_\_\_\_\_

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10/29, 191\_\_\_\_  
(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:

Fracture of 3-5 & 4th  
cervical vertebrae.(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.Contributory accident thrown from  
(SECONDARY) train car(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.(Signed) H. G. [Signature] M. D.191\_\_\_\_ (Address) Springfield, 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 \_\_\_\_\_

DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_

ADDRESS \_\_\_\_\_

Original file, date \_\_\_\_\_, 19\_\_\_\_

All information called for must be written on this Supplementary Certificate.

N. P. Gageboom, Springfield

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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