

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Juengston

Township _____

or _____

Village _____

or _____

City Chillicothe Mo.Registration District No. 508File No. 35144Primary Registration District No. 3026Registered No. 107

St.: _____ Ward) _____

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

FULL NAME Carl Willie Griffin

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Black SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)DATE OF BIRTH Oct 23, 1911
(Month) (Day) (Year)AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
yrs. mos. 3 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) Chillicothe Mo.NAME OF FATHER Mr. GriffinBIRTHPLACE OF FATHER
(City or town, State or foreign country) Don't knowMAIDEN NAME OF MOTHER Fannie E. BruceBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Brunswick Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carline Bruce X(ADDRESS) Chillicothe Mo. XFiled 10/25, 1911, R. Barney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 25, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Oct. 22, 1911, to Oct. 25, 1911, that I last saw him alive on Oct. 22, 1911, and that death occurred, on the date stated above, at 3 A m. The CAUSE OF DEATH* was as follows:Malnutrition158 (Duration) _____ yrs. 151 mos. 3 ds.

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

(Signed) M. M. A. Maney M. D. Oct. 25, 1911 (Address) Chillicothe 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 Col. Cemetery South DATE OF BURIAL Oct 25, 1911UNDERTAKER F. B. Norman ADDRESS Chillicothe 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*, *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.)



County St. Louis

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

CERTIFICATE OF DEATH

Township _____
or
Village _____
or
City Madison

Registration District No. 578
226

File No. _____
Registered No. 107

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

FULL NAME

Carl Willie Siffer

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|-----------------------------------|---|
| SEX <u>M.</u> | COLOR OR RACE <u>B.</u> | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S.</u> |
| DATE OF BIRTH <u>Oct 22 1911</u> (Month) (Day) (Year) | | |
| AGE <u>3</u> yrs. mos. ds. | If LESS than 1 day, hrs. or min.? | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 25 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to Oct 25, 1911, that I last saw him alive on Oct 22, 1911, and that death occurred, on the date stated above, at 3 1/2 m.

The CAUSE OF DEATH* was as follows:

Not sufficiently nourished in utero
(Duration) yrs. mos. ds.

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) St. Louis, Mo.

PARENTS

NAME OF FATHER Mr. Siffer

BIRTHPLACE OF FATHER St. Louis, Mo.

MAIDEN NAME OF MOTHER Anna C. Bruce

BIRTHPLACE OF MOTHER St. Louis, Mo.

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

(Signed) [Signature] Oct 25 1911 (Address) [Address]

*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) Carl Siffer

(ADDRESS) [Address]

Filed Nov 30 1911 A. Barney REGISTRAR

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 Oct 25 1911

UNDERTAKER [Signature] ADDRESS [Address]

Original file, date Oct 25 1911

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

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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