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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Pettis

Township ____ or Village ____ or City Sedalia Mo (NO. ____ St.: ____ Ward)

Registration District No. 668 File No. 25599

Primary Registration District No. 3032 Registered No. 263

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

FULL NAME Louis Williams

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 23, 1892 (Month) (Day) (Year)

AGE 19 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work R R Shopman
(b) General nature of industry, business, or establishment in which employed (or employer) Mo Pac Ry Co

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

PARENTS

NAME OF FATHER	Joseph Williams
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Mo
MAIDEN NAME OF MOTHER	Lucy Kiger
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucy Morgan Sedalia Mo

(ADDRESS) 420 E Johnson

Filed Oct 16, 1911. Sam Kelly Register
Bess Rahrs Deputy.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 13, 1911 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 12, 191__, to ____, 191__, that I last saw him alive on Oct 13, 191__, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

(a) Drowning in creek

(b) ____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) P. R. Mueller M. D.

Oct 14, 1911 (Address) Sedalia 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
Bunceton Mo	Oct 16, 1911

UNDERTAKER	ADDRESS
Sedalia Und. Co.	Sedalia 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. 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, Sarcoma,* 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 *septichaemia,*" "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.)

HUGH STEPHENS, JEFFERSON CITY.

PLACE OF DEATH

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

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

County ____

Township or Village or City: Sedalia (NO. ____ St.; ____ Ward)

Registration District No. 668 — File No. 35509

Primary Registration District No. ____ — Registered No. ____

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

FULL NAME Harris William

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX ____ | COLOR OR RACE ____ | SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) ____

DATE OF BIRTH ____ (Month) ____ (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) ____

PARENTS
- 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 (Month) 13 (Day), 1911 (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:

Drowning

169 Accidental X

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

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

(Signed) F. R. Morley X M. D.

April 16, 1920 (Address) Sedalia 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. B.—Every item of information should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

F. R. Morley Sedalia

Revised United States Standard Certificate of Death

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

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