

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  
 County Dade  
 Township Washington Registration District No. 239 File No. 27427  
 or  
 Village \_\_\_\_\_ Primary Registration District No. 5319 Registered No. \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William Rufus Tucker.

**PERSONAL AND STATISTICAL PARTICULARS**

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>yes</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>March 14, 1858</u> (Month) (Day) (Year)		
AGE <u>54</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-02</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Dade Co.</u>		
PARENTS	NAME OF FATHER <u>Jim Tucker</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Dont know</u>	
	MAIDEN NAME OF MOTHER <u>Martha Chapel</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Dont know</u>	

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Nov. 1st  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 15, 1911, to Nov. 1st, 1911,  
 that I last saw him alive on \_\_\_\_\_, 1911,  
 and that death occurred, on the date stated above, at 1:30 P.M.  
 The CAUSE OF DEATH\* was as follows:  
Stomach and Lung Trouble

Contributory  
(SECONDARY)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) J. J. Martin M. D.  
 1911 (Address) Greenfield 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 <u>Greenfield</u>	DATE OF BURIAL <u>Nov. 3</u> , 1911
UNDERTAKER <u>H. Harrison</u>	ADDRESS <u>Greenfield Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Albert Trecken  
 (ADDRESS) Greenfield Mo.  
 Filed Nov 20 1911. E. H. Gray  
 REGISTRAR

# 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 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.)



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 Dade  
Township Washington  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 237 File No. 37427  
Primary Registration District No. 6329 Registered No. \_\_\_\_\_

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

**FULL NAME** William Rufus Tucker

**PERSONAL AND STATISTICAL PARTICULARS**

<b>SEX</b> <u>Male</u>	<b>COLOR OR RACE</b> <u>White</u>	<b>SINGLE MARRIED WIDOWED OR DIVORCED</b> <u>ma</u> (Write the word)
<b>DATE OF BIRTH</b> _____ (Month) (Day) (Year)		
<b>AGE</b> <u>54</u> yrs. <u>X</u> mos. <u>X</u> ds.		<b>IF LESS than 1 day, ___ hrs. or ___ min.?</b>
<b>OCCUPATION</b> (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
<b>BIRTHPLACE</b> (City or town, State or foreign country) <u>Dade Co</u>		
<b>PARENTS</b>	<b>NAME OF FATHER</b> <u>Jim Tucker</u>	
	<b>BIRTHPLACE OF FATHER</b> (City or town, State or foreign country) <u>Don't know</u>	
	<b>MAIDEN NAME OF MOTHER</b> <u>Marsha Chapel</u>	
	<b>BIRTHPLACE OF MOTHER</b> (City or town, State or foreign country) <u>Don't know</u>	

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH**  
Nov 1st 1st, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 15, 1910, to Nov 1st, 1911, that I last saw him alive on Nov 1st, 1911, and that death occurred, on the date stated above, at 1:30 pm.  
The CAUSE OF DEATH\* was as follows:  
Stomach and kidney trouble

**Contributory**  
(SECONDARY)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. P. Martin M. D.  
1911 (Address) Greenville 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Albert Trecker  
(ADDRESS) Greenville Mo  
Filed Nov 4<sup>th</sup> 1911. W A Wolfe REGISTRAR

**PLACE OF BURIAL OR REMOVAL**  
Greenville  
**DATE OF BURIAL**  
Nov 3, 1911  
**UNDERTAKER**  
Harrison  
**ADDRESS**  
Greenville Mo

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