

PLACE OF DEATH

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

Township _____

Registration District No. 651File No. 42230

Village _____

Primary Registration District No. 4384Registered No. 217City Leanshessville (NO. _____)

St. _____ Ward _____

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

FULL NAME William Whittlesy

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH Don't know
(Month) _____ (Day) _____ (Year) _____AGE about 40 yrs If LESS than 1 day, ____ hrs. or ____ min.?
yrs. ____ mos. ____ ds.OCCUPATION (a) Trade, profession, or particular kind of work Optician
(b) General nature of industry, business, or establishment in which employed (or employer) _____BIRTHPLACE (City or town, State or foreign country) Martin TennNAME OF FATHER Thos. WhittlesyBIRTHPLACE OF FATHER (City or town, State or foreign country) don't knowMAIDEN NAME OF MOTHER don't knowBIRTHPLACE OF MOTHER (City or town, State or foreign country) don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. H. J. Finer(ADDRESS) LeanshessvilleFiled Dec 21, 1911 B. D. Brown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 19, 1911
(Month) _____ (Day) _____ (Year) _____I HEREBY CERTIFY, that I attended deceased from Dec. 17, 1911, to Dec 19, 1911, that I last saw him alive on Dec. 19, 1911, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia
108
PP
(Duration) _____ yrs. ____ mos. ____ ds.Contributory (SECONDARY) _____
(Duration) _____ yrs. ____ mos. ____ ds.(Signed) T. B. Lowe M. D.
12/21, 1911 (Address) Leanshessville

*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 Country farm DATE OF BURIAL 12/21, 1911UNDERTAKER Al. LaFoye ADDRESS eville

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 Pemiscot

Township _____
or
Village _____
or
City Caruthersville (NO. _____)

Registration District No. 651
Primary Registration District No. 4388

File No. _____
Registered No. 211

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

FULL NAME William N. Whittlesy

(*) PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>Don't know</u> (Month) (Day) (Year)		
AGE <u>About 40</u> yrs. mos. ds.		If LESS than 1 day, hrs. or min.
OCCUPATION (a) Trade, profession, or particular kind of work <u>Optician</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Martin Tenn.</u>		
PARENTS	NAME OF FATHER <u>Thos. Whittlesy</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	
	MAIDEN NAME OF MOTHER <u>Don't know</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 19, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to _____, 1911, that I last saw h _____ alive on _____, 1911, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) _____ yrs. _____ mos. 7 ds.

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

(Signed) B. F. Jones M. D.
12/21 1911 (Address) Caruthersville

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. B. F. Jones
(ADDRESS) Caruthersville

*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 _____

Filed 2/15 1912 B. Desaney REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>County Fair</u>	DATE OF BURIAL <u>12/21</u> 191 <u>1</u>
UNDERTAKER <u>A. C. La Forge</u>	ADDRESS <u>Civil</u>

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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