

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

PLACE OF DEATH
County St. Clair
Township Osceola
or
Village Osceola
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 764 File No. 3642500
Primary Registration District No. 4460 Registered No. _____

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

FULL NAME William W. Hibbs

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 18, 1890
(Month) (Day) (Year)

AGE 21 yrs. 8 mos. 15 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 3-677

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

PARENTS
NAME OF FATHER John W. Hibbs
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Constance A. Cramer
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Hibbs
(ADDRESS) 71 Osceola mo
Filed Dec. 6, 1911 R. Seever
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 30, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from October 29th, 1911, to Dec. 30th, 1911, that I last saw him alive on Dec. 3rd, 1911, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

23A
(Duration) _____ yrs. 9 mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. C. Ward M. D.
Dec. 5th, 1911 (Address) Osceola, 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 Osceola mo DATE OF BURIAL Dec 5, 1911
UNDERTAKER L. E. Giver ADDRESS Osceola mo

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.

United States Standard Certificate of Death

U. S. Census and American Public Health Association]

before air head
 at; it should be use
 Spinner, (b) Cotton
 Foreman, (b) Auto
 n may form part o
 urn "Laborer," "For
 hout more precise
 er, Laborer—Coal
 engaged in the dut
 ekeepers who recei
 Housewife, Housew
 uly employed, as A
 en to report specific
 in domestic servic
 aid, etc. If the
 p on account of t
 ration at beginnin
 s, that fact may
 yrs.). For persons
 write None.

of occupation.—Precise statement of occu-
 ry important, so that the relative health-
 rious pursuits can be known. The ques-
 each and every person, irrespective of
 ny occupations a single word or term on-
 will be sufficient, e. g., *Farmer* or *Planter*,
 mpositor, *Architect*, *Locomotive engineer*,
 Stationary fireman, etc. But in many
 ly in industrial employments, it is neces-
 (a) the kind of work and also (b) the
 business or industry, and therefore an
 is provided for the latter statement; it
 d only when needed. As examples: (a)

cause of death—(the primary
 causation), using
 the same disease
 only definite syn-
 ingitis"); *Diphtheri*
 fever (never rep
 pneumonia); *Broncho*
 l, is indefinite); *T*),
 um, etc., *Carcinoma*
 origin; "Cancer"
 for malignant

ice for wages, as *Servant*, *Cook*, *House-*
maid, 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 busi-
 ness, that fact may be indicated thus: *Farmer (re-*
tired, 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 re-
 spect to time and causation), using always the same
 accepted term for the same disease. Examples:
meningitis"); *Diphtheria* (avoid
 "Croup"); *Typhoid fever* (never report "T
 pneumonia"); *Lobar pneumonia*; *Bronchopne*
 ("Pneumonia," unqualified, is indefinite); *Tuber-*
of lungs, meninges, peritonaeum, etc., *Carcinoma*

coma, etc., of (name origin; "Cancer" is
 less definite; avoid use of "Tumor" for malignant
 neoplasms); *Measles*; *Whooping cough*; *Chronic valvu-*
lar heart disease; *Chronic interstitial nephritis*, etc. The
 contributory (secondary or intercurrent) affection need
 not be stated unless important. Example: *Measles* (dis-
 ease causing death), *29 ds.*; *Bronchopneumonia* (sec-
 ondary), *10 ds.* Never report mere symptoms or ter-
 minal conditions, such as "Asthenia," "Anaemia"
 (merely symptomatic), "Atrophy," "Collapse," "Coma,"
 "Convulsions," "Debility" ("Congenital," "Senile," etc.),
 "Dropsy," "Exhaustion," "Heart failure," "Haemor-
 rhage," "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 under-
 taken. 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 na-
 ture of the injury, as fracture of skull, and conse-
 quences (e. g., *sepsis*, *tetanus*) may be stated under the
 head of "Contributory." (Recommendations on state-
 ment of cause of death approved by Committee on
 Nomenclature of the American Medical Association.)