

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

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 Bright Co
 County Bright Co Inter Grove
 Township Children Home Registration District No. 908 File No. 3983
 or Inter Grove
 Village Inter Grove Primary Registration District No. 6222 Registered No. 6
 or Children Home (NO. _____) St. _____ Ward _____
 City Children Home (NO. _____) St. _____ Ward _____
 FULL NAME Alfred Allen [If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) _____
 DATE OF BIRTH Oct 21st 1911
 (Month) (Day) (Year)
 AGE 2 yrs. 27 mos. 27 ds. IF LESS than 1 day, ____ hrs. or ____ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) 0
 BIRTHPLACE (City or town, State or foreign country) Springfield Mo
 NAME OF FATHER Allen
 BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown
 MAIDEN NAME OF MOTHER Ethel Allen
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 17, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw him alive on Jan 17, 1912,
 and that death occurred, on the date stated above, at 2 A.M.
 The CAUSE OF DEATH* was as follows:
Heart Failure
107A
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. C. Lane M. D.
1/19, 1912 (Address) Inter Grove Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. A. Brown Sec.
 (ADDRESS) Children's Home
 Filed Jan 19, 1912. E. J. Butzke
 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? Children's Home
 Former or usual residence Springfield Mo
 PLACE OF BURIAL OR REMOVAL Children's Home DATE OF BURIAL Jan 18, 1912
 UNDERTAKER H. J. Fenwick ADDRESS Inter Grove

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, 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.)



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PLACE OF DEATH

County

Township

Village

City

FULL NAME

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

Registration District No.

File No.

Primary Registration District No.

Registered No.

St.

Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

SEX *M* COLOR OF RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH *10/11/91*
(Month) (Day) (Year)

AGE *7 27* If LESS than 1 day, hrs. or min. or 2 mos. 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)

PARENTS
NAME OF FATHER *Allen*
BIRTHPLACE OF FATHER *Illinois*
MAIDEN NAME OF MOTHER *Edith Allen*
BIRTHPLACE OF MOTHER *Illinois*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *E. J. Butzke*
(ADDRESS) *Children Home*

Filed *Jan 19 1912*
REGISTRAR *E. J. Butzke*

Original file, date *JAN 1912*

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *1-17*, 191*2*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *1-17*, 191*2*, to *1-17*, 191*2*, that I last saw h. alive on *1-17*, 191*2*, and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:
Pneumonia Catarrhal
(Duration) yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.
(Signed) *W. C. Long* M. D.
1117 (Address) *Madison Ave*

*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? *Children Home*
If not at place of death?

Former or usual residence *Spfield*

PLACE OF BURIAL OR REMOVAL *Children Home* DATE OF BURIAL *1-18*, 191*2*

UNDERTAKER *W. J. Fenwick* ADDRESS *Madison Ave*

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

Revised United States Standard Certificate of Death

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