

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
County Cutler
Township Ash Hill
or
Village Disc
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 925 File No. 4346
Primary Registration District No. 51340 Registered No. 7

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

FULL NAME Willie Pipkins

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED single
(Write the word)

DATE OF BIRTH Nov 15, 1911
(Month) (Day) (Year)

AGE 2 yrs. 2 mos. 17 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Infant at home
(b) General nature of industry, business, or establishment in which employed (or employer)

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

PARENTS
NAME OF FATHER Wm Pipkins
BIRTHPLACE OF FATHER Mo
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Willie Pipkins
BIRTHPLACE OF MOTHER Mo
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Pipkins
(ADDRESS) Trisk Mo

Filed Feb 1912 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 2, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 20, 1911, to Feb 1, 1912, that I last saw her alive on Jan 1, 1912, and that death occurred, on the date stated above, at 2 a.m.
The CAUSE OF DEATH* was as follows:

Whooping cough
9 1/2
(Duration) yrs. 1 mos. ds.

Contributory (Secondary) _____ (Duration) yrs. _____ mos. _____ ds.
(Signed) John M. Blust M. D.
1912 (Address) _____

*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 Ash Hill DATE OF BURIAL 2-8-1912
UNDERTAKER Lia & Jas Warren Trisk Mo ADDRESS _____

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.)



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

PLACE OF DEATH
 County Butter
 Township Ash Steel
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 925 File No. 4346
 Primary Registration District No. 51340 Registered No. 7

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

FULL NAME Willie Pipkins

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (#rite the word) S.

DATE OF DEATH _____, 1912
 (Month) Feb (Day) 2 (Year)

DATE OF BIRTH Nov. 15, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 20, 1911, to Feb 1, 1912, that I last saw her alive on Jan 20, 1912, and that death occurred, on the date stated above, at 2 a.m.

AGE _____ yrs. 2 mos. 17 ds. IF LESS than 1 day, _____ hrs. or _____ min.

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Infant at home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

Whooping cough.
 (Duration) _____ yrs. _____ mos. _____ ds.

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

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

PARENTS
 NAME OF FATHER Wm. Pipkins
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
 MAIDEN NAME OF MOTHER Wegie Pipkins
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

(Signed) John L. M. Aisher M. D.
2-37 1912 (Address) Fisk Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Wm. Pipkins
 (ADDRESS) Fisk 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 _____

Filed 2-3 1912 Wm. H. Gresham REGISTRAR

PLACE OF BURIAL OR REMOVAL Ash Steel DATE OF BURIAL 2/3 1912
 UNDERTAKER L.A. & Jas. Warren ADDRESS Fisk Mo.

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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.)