

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

PLAGE OF DEATH
County Cooper ✓
Township _____ or _____
Village _____ or _____
City Boonville (NO. _____) St. _____ Ward _____
Registration District No. 218 File No. 4625
Primary Registration District No. 3015 Registered No. 14
FULL NAME Freddie Stanfield Mo. Boonville
[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>	DATE OF DEATH <u>Feb 24</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>March 25</u> , 189 <u>8</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Feb 23rd</u> , 191 <u>2</u> , to <u>Feb 24th</u> , 191 <u>2</u> , that I last saw him alive on <u>Feb 24th</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>4 P. M.</u> . The CAUSE OF DEATH* was as follows: <u>Cerebro spinal meningitis</u>	
AGE <u>14</u> yrs. <u>10</u> mos. <u>30</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?	6/18 (Duration) ___ yrs. ___ mos. ___ ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Pipe Factory</u>			Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds. (Signed) <u>G. L. Evans</u> M. D. <u>Feb 26</u> 191 <u>2</u> (Address) <u>Boonville Mo</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Cooper 3rd</u> <u>Mo</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>Wm</u> <u>Stanfield</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Indiana</u>		Where was disease contracted if not at place of death? Former or usual residence.	
	MAIDEN NAME OF MOTHER <u>Agnes Nold</u>		PLACE OF BURIAL OR REMOVAL <u>Walnut Grove</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Cooper</u> <u>Mo</u>		DATE OF BURIAL <u>Feb 26</u> , 191 <u>2</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm</u> <u>Stanfield</u> (ADDRESS) <u>Boonville Mo</u>			UNDERTAKER <u>J. H. Goodman</u>	
File <u>Feb. 26,</u> 191 <u>2</u> <u>J. H. Goodman</u> REGISTRAR			ADDRESS <u>Boonville Mo</u>	

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 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.)



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

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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Cooper

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

Township _____

Registration District No. 218

File No. 4625

Village _____

Primary Registration District No. 3015

Registered No. 14

City Bronville

St. _____ Ward _____

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

FULL NAME

Fredie Stauffer

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Mar 25, 1898
(Month) (Day) (Year)

AGE 14 yrs. 10 mos. 30 ds.
If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION (a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) Pipe Factory

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

PARENTS
NAME OF FATHER Wm Stauffer
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind
MAIDEN NAME OF MOTHER Gyres Wood
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Cooper Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Stauffer
(ADDRESS) Bronville Mo

Filed Apr 10, 1912 W. H. Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 24, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 23, 1912 to Feb 24, 1912, that I last saw him alive on Feb 24, 1912, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis Epidemic

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

(Signed) R. D. Erans M. D. April 10, 1912 (Address) Bronville 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 Walnut Grove DATE OF BURIAL 2/26, 1912

UNDERTAKER J. A. Goodman ADDRESS Bronville Mo

Revised United States Standard Certificate of Death

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Association]

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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 "*Asithenia, "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.)