

MAKING 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 Newton
Township _____
or
Village _____
or
City Neosho (NO. _____ St.: _____ Ward)

Registration District No. 609 File No. 6130
Primary Registration District No. 4363 Registered No. 17

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

FULL NAME Verne Llewellyn Williams

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)	DATE OF DEATH <u>Feb 13th</u> 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>May 8</u> 188 <u>9</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Feb 8th</u> 191 <u>2</u> , to <u>Feb 13th</u> 191 <u>2</u> , that I last saw him alive on <u>Feb 13th</u> 191 <u>2</u> , and that death occurred, on the date stated above, at <u>10³⁰</u> p.m.	
AGE <u>22</u> yrs. <u>9</u> mos. <u>31</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Cerebro spinal Meningitis</u> <u>993 of</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Railway mail clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Mo & N. Ark RR.</u>			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Sanchar Miss</u>			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Llewellyn Williams</u>		(Signed) <u>W. Lawson</u> M. D. <u>Feb 14</u> 191 <u>2</u> (Address) <u>Neosho Mo</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Moales.</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER <u>Mary A. Benson</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 MOTHER (City or town, State or foreign country) <u>Ohio</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Llewellyn Williams</u> (ADDRESS) <u>Marshall Ark.</u>				
Filed <u>Feb 21</u> 191 <u>2</u> , <u>W. R. Watson</u> <u>Deputy</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>500 Cemetery</u> UNDERTAKER <u>F. J. Byham Co</u>	
			DATE OF BURIAL <u>Feb 15</u> 191 <u>2</u> ADDRESS <u>Neosho Mo</u>	

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____ WIDOWED _____ OR DIVORCED _____ (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year) _____

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

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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed) _____ (Address) _____, 191____ M. D. _____

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

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

*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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____

Filed _____, 191____ REGISTRAR _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK

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

PLACE OF DEATH

County Newton

Township _____

or Village _____

or City Neosho (NO. _____)

Registration District No. 609

File No. 6130

Primary Registration District No. 4363

Registered No. 12

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

FULL NAME Vernie Lewellyn Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED m (Write the word)

DATE OF BIRTH May 8, 1889 (Month) (Day) (Year)

AGE 22 yrs. 9 mos. 5 ds. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work R. R. mail clerk (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) San Carlos, Wis.

PARENTS NAME OF FATHER Llewellyn Williams BIRTHPLACE OF FATHER (City or town, State or foreign country) Wales MAIDEN NAME OF MOTHER Margd. Benson BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE, (Informant) Llewellyn Williams (ADDRESS) Marshall Ave.

Filed April 9, 1912 Worland - Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 13, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 8, 1912, to Feb 13, 1912, that I last saw him alive on Feb 13, 1912 and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows: Cerebro Spinal meningitis Deceased a mail clerk. His run was through inspected district. He probably contracted it in Ark. No spread from his car (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) R. Larson M. D. April 9, 1912 (Address) Neosho 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 L.O.O.F. Cem DATE OF BURIAL Feb 15, 1912 UNDERTAKER F. J. Beyham Co ADDRESS Neosho Mo

RECORD THIS IS A F. A. M. A. N. E. RECORD WITH THE F. A. M. A. N. E. 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. "X3" Repts.

MISSOURI SUPPLEMENTARY

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*, *Sarcoma*, 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.)