

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 Oregon ✓
Township Falling Springs Registration District No. 633 File No. 6186
or
Village _____ Primary Registration District No. 55-36 Registered No. 8
or
City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Samuel Decker

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>married</u>	DATE OF DEATH <u>December</u> <u>12</u> , 191 <u>1</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>August</u> <u>14</u> , 19 <u>50</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Sept 15</u> , 191 <u>0</u> , to <u>Dec 12</u> , 191 <u>1</u> , that I last saw him alive on <u>Dec 9</u> , 191 <u>1</u> , and that death occurred, on the date stated above, at <u>5 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Heart Failure</u> <u>caused by Paralysis</u>	
AGE <u>62</u> yrs. <u>8</u> mos. <u>2</u> ds.			IF LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1-02</u>			83 <u>83</u> (Duration) <u>2</u> yrs. <u>8</u> mos. <u>6</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Arkansas</u>			Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>George Decker</u>		(Signed) <u>J. C. Dunigan</u> M. D. (Address) <u>Bradwell, Mo.</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Arkansas</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>Mimie Mamerl</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>Arkansas</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>J. H. Sisco</u> (ADDRESS) <u>Green Mo</u>				
Filed <u>Feb 22</u> , 191 <u>2</u> , at <u>Green Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Roll Cemetery</u> UNDERTAKER <u>J. H. Sisco</u>	
REGISTRAR			DATE OF BURIAL <u>Dec 13</u> , 191 <u>1</u> ADDRESS <u>Green 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*, *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.)



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MISSOURI STATE BOARD OF HEALTH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Oregon
Township Sullivan Epi
or
Village _____
or
City _____ (NO. _____)

Registration District No. 633 File No. _____
Primary Registration District No. 5836 Registered No. 8
St. _____ Ward _____

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

FULL NAME Lemuel Decker

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Aug 14, 1850
(Month) (Day) (Year)

AGE 62 yrs. 8 mos. 2 ds. If LESS than 1 day, _____ hrs. or _____ min.

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

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

PARENTS
NAME OF FATHER George Decker
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark
MAIDEN NAME OF MOTHER Marie Manners
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Susca
(ADDRESS) Greer Mo

Filed April 11 1911 Wes Leslie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 12, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 11, 1911, to Dec 11, 1911, that I last saw h alive on Dec 9, 1911, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Heart failure & Due to general Paralysis of course
(Duration) 1 yrs. 3 mos. 1 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Y. C. Hennigan M. D.
April 13 1912 (Address) Braswell 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 Ross Cem DATE OF BURIAL Dec 13, 1911
UNDERTAKER T. H. Susca ADDRESS Greer Mo

Revised United States Standard Certificate of Death

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