

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 Shelby  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 82d File No. 7800  
Primary Registration District No. 4508 Registered No. 8

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

FULL NAME Dr. William C. Sprinkle

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>Dec 13</u> 18 <u>49</u> (Month) (Day) (Year)		
AGE <u>62</u> yrs. <u>2</u> mos. <u>6</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Physician</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Physician -</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Hannibal Mo</u>		
PARENTS	NAME OF FATHER <u>David A Sprinkle</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Columbia, Missouri</u>	
	MAIDEN NAME OF MOTHER <u>Fannie Sprinkle</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Hannibal Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 19 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 17, 1912, to Feb 19, 1912, that I last saw him alive on Feb 18, 1912, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH\* was as follows:  
11A Pneumonia  
107A

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory (SECONDARY) Asiatic Cholera  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 20 ds.

(Signed) H. C. Vaughan M. D.  
Date Feb 19 1912 (Address) Shelburne 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Geo. V. Sprinkle  
(ADDRESS) Garrison Home Co

Filed 2-19 1912 R. D. Butcher  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Indian Creek Cemetery DATE OF BURIAL Feb 20 1912  
UNDERTAKER Coza Peter ADDRESS Shelburne

# 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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PLACE OF DEATH

County Shelby

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

Township Shelburne

Registration District No. 830

File No. 7800

Village Shelburne

Primary Registration District No. 4503

Registered No. 8

City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Dr. William C Sprinkle

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 19, 1912  
(Month) (Day) (Year)

DATE OF BIRTH Dec 13, 1849  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 17, 1912, to Feb 19, 1912  
that I last saw him alive on 2/18, 1912,  
and that death occurred, on the date stated above, at 8 A m.

AGE 62 yrs. 2 mos. 6 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The CAUSE OF DEATH\* was as follows:  
Pneumonia & Broncho

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

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

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.  
Contributory Los Gippe  
(SECONDARY)

NAME OF FATHER David Sprinkle

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 20 ds.  
(Signed) H. C. Vaughan M. D.  
\_\_\_\_\_ 1912 (Address) Shelburne

BIRTHPLACE OF FATHER (City or town, State or foreign country) Columbia Mo

MAIDEN NAME OF MOTHER Church

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Hannibal mo

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Geo S. Sprinkle

Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

(ADDRESS) Granville Monroe Co

PLACE OF BURIAL OR REMOVAL Ind. Creek

DATE OF BURIAL 2/20, 1912

Filed April 8, 1912. R. D. Batterby REGISTRAR

UNDERTAKER Cyra Peter

ADDRESS Shelburne

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