

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Cooper</i>	Registration District No.	<i>228</i>	File No.	<i>8702</i>
Township or Village	<i>South Mountain</i>	Primary Registration District No.	<i>5310</i>	Registered No.	<i>6</i>
City	(NO. _____) _____	St.	_____	Ward)	_____
FULL NAME <i>Richard J. Pope</i>			[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 <i>Male</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <i>Married</i>	DATE OF DEATH <i>2</i> <i>March 14</i> , 191 <i>2</i> (Month) (Day) (Year)		
DATE OF BIRTH <i>Aug 31</i> , 18 <i>34</i> (Month) (Day) (Year)		I HEREBY CERTIFY, that I attended deceased from <i>March 1</i> , 191 <i>2</i> , to <i>March 14</i> , 191 <i>2</i> , that I last saw him alive on <i>March 13</i> , 191 <i>2</i> , and that death occurred, on the date stated above, at <i>7 P.</i> m. The CAUSE OF DEATH* was as follows: <i>Bronchitis</i>			
AGE <i>22</i> yrs. <i>6</i> mos. <i>11</i> ds.	IF LESS than 1 day <input checked="" type="checkbox"/> hrs. or <input type="checkbox"/> min.?		<i>1960 D</i> <i>1256 U</i>		
OCCUPATION (a) Trade, profession, or particular kind of work <i>Farmer</i>		1960 D 1256 U			
(b) General nature of industry, business, or establishment in which employed (or employer) <i>1-02</i>		The CAUSE OF DEATH* was as follows: <i>Bronchitis</i>			
BIRTHPLACE. (City or town, State or foreign country) <i>Cumberland Gap Ky</i>		(Duration) <input checked="" type="checkbox"/> yrs. <i>8</i> mos. <i>0</i> ds.			
PARENTS	NAME OF FATHER	Contributory (SECONDARY) <i>Chronic Cystitis</i>			
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	(Duration) <i>10</i> yrs. <input checked="" type="checkbox"/> mos. <input checked="" type="checkbox"/> ds.			
	MAIDEN NAME OF MOTHER	(Signed) <i>J. C. Gundersen</i> M. D. <i>March 16</i> , 191 <i>2</i> (Address) <i>Clarksburg Mo</i>			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____		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 _____			
(ADDRESS) _____		PLACE OF BURIAL OR REMOVAL <i>Pisgah Cur</i>		DATE OF BURIAL <i>March 16</i> , 191 <i>2</i>	
Filed <i>March 17</i> , 191 <i>2</i>	REGISTRAR <i>A. Williams</i>		ADDRESS <i>California Mo</i>		

# 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.)



NON-FADING 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  
Township S. Mountain  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 228 File No. 8702  
Primary Registration District No. 5316 Registered No. 6

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

FULL NAME Richard T. Pope

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar 14, 1912  
(Month) (Day) (Year)

DATE OF BIRTH Aug 31, 1939  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 14, 1912, to Mar 14, 1912, that I last saw him alive on Mar 13, 1912, and that death occurred, on the date stated above, at 7 P. m.

AGE 72 yrs. 6 mos. 11 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 Farm  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

Chronic Bronchitis  
(Duration) \_\_\_\_\_ yrs. 8 mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) Cumbeledge Ky

Contributory Chronic Cystitis  
(SECONDARY) (Duration) 10 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PARENTS  
NAME OF FATHER Don't know  
BIRTHPLACE OF FATHER Don't know  
MAIDEN NAME OF MOTHER Don't know  
BIRTHPLACE OF MOTHER Don't know

(Signed) H. C. Freudenberger M. D.  
\_\_\_\_\_ 1912 (Address) Clarkburg Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Edward Clutter  
(ADDRESS) Clarkburg Mo.

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

Filed March 15, 1912 H. C. Freudenberger REGISTRAR

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 Desha Cem DATE OF BURIAL Mar 16, 1912

UNDERTAKER W. Williams ADDRESS Calefornia Mo

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