

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.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<u>Iron</u>	Registration District No.	<u>293</u>
Township	<u>Dent</u>	File No.	<u>5104</u>
Village	<u>Libermans</u>	Primary Registration District No.	<u>5548</u>
City	<u>Libermans</u> (NO. _____ St.: _____ Ward)	Registered No.	<u>14</u>
FULL NAME		[If death occurred in a hospital or institution, give its NAME instead of street and number]	
<u>Denney, Clarence, Prof.</u>			
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH
<u>Male</u>	<u>white</u>		<u>March 20</u> , 191 <u>2</u>
DATE OF BIRTH			(Month) (Day) (Year)
<u>April 6</u> , 19 <u>10</u>			
AGE			I HEREBY CERTIFY, that I attended deceased from
<u>1</u> yrs. <u>11</u> mos. <u>22</u> ds.			<u>March 1st</u> , 191 <u>2</u> , to <u>March 25th</u> , 191 <u>2</u> ,
OCCUPATION			that I last saw him alive on <u>March 15th</u> , 191 <u>2</u> ,
(a) Trade, profession, or particular kind of work			and that death occurred, on the date stated above, at <u>5 a.</u> m.
(b) General nature of industry, business, or establishment in which employed (or employer)			The CAUSE OF DEATH* was as follows:
<u>0</u>			<u>Morassimus</u>
BIRTHPLACE (City or town, State or foreign country)			<u>234</u>
<u>St. Francis Mo</u>			<u>W</u>
PARENTS	NAME OF FATHER	(Duration)	yrs. <u>2</u> mos. _____ ds.
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	Contributory (SECONDARY)	<u>Hereditary Tuberculosis</u>
	MAIDEN NAME OF MOTHER	(Duration)	yrs. _____ mos. _____ ds.
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	(Signed)	<u>R. L. Purkin</u> M. D.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			(Address) <u>Dillard Ave</u>
(Informant) <u>Sol. Bays</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
(ADDRESS) <u>Libermans, Mo</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
Filed	<u>Mar 27</u> , 191 <u>2</u>	<u>Solomon Bays</u>	At place of death <u>8</u> yrs. <u>2</u> mos. <u>0</u> ds. In the State _____ yrs. _____ mos. _____ ds.
	<u>Mar 27</u> , 191 <u>2</u>	<u>Sol.</u> REGISTRAR	Where was disease contracted if not at place of death? _____
			Former or usual residence _____
			PLACE OF BURIAL OR REMOVAL
			<u>Pleasant Grove</u>
			DATE OF BURIAL
			<u>Mar 26</u> , 191 <u>2</u>
			UNDERTAKER
			<u>Country</u>
			ADDRESS
			<u>Not known</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, peritonaeum*, 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 Iron
 Township West
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 393 File No. _____
 Primary Registration District No. 5548 Registered No. 14

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

FULL NAME

Devey Clarence Propp

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
 DATE OF BIRTH April 6, 1910
 (Month) (Day) (Year)
 AGE 1 yrs. 11 mos. 2 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) St. Francis Co. Mo.

NAME OF FATHER Jesse Propp

BIRTHPLACE OF FATHER (City or town, State or foreign country) Franklin Co. Mo.

MAIDEN NAME OF MOTHER Algie Stringer

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Crawford Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Ed. Keys

(ADDRESS) Viburnum Mo.

Filed FEB 27 1912 F. M. Adams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar. 25, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 1, 1912, to Mar. 25, 1912
 that I last saw him alive on Mar. 15, 1912
 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Marasmus

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

Contributory Hereditary Tuberculosis
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. C. Parker M. D.
Mar. 2, 1912 (Address) Shilard 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, TRANSCIENTS, 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 Pleasant Grove Cem. DATE OF BURIAL Feb. 26, 1912

UNDERTAKER Not known ADDRESS _____

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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