

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

County Christian
 Township Sinegar
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 192 File No. 16525
 Primary Registration District No. 5852 Registered No. 28

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

FULL NAME Joe E. Egan

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Boy</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>May 10, 1912</u> (Month) (Day) (Year)		
AGE <u>20 months</u> X yrs. X mos. X ds. IF LESS than 1 day, ___ hrs. or ___ min.?		

OCCUPATION
 (a) Trade, profession, or particular kind of work _____ X

(b) General nature of industry, business, or establishment in which employed (or employer) _____ X O

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

PARENTS	NAME OF FATHER <u>Joe E. Egan</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>
	MAIDEN NAME OF MOTHER <u>Jessie Jones</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE X

(Informant) _____

(ADDRESS) _____

Filed May 10 19121912REGISTRAR J. R. Appleby

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 10th, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 10, 1912, to May 10, 1912, that I last saw him alive on May 10, 1912, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Only lived 20 minutes after birth
Poor Circulation | 5 |
158 (Duration) X yrs. X mos. X ds.

Contributory _____
 (SECONDARY) _____

(Signed) A. A. [Signature] M. D.
May 10, 1912 (Address) Lebanon 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

Laura Chappell

DATE OF BURIAL

May 11 1912

UNDERTAKER

Sam Imagine

ADDRESS

Booy

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*, *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.)



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

PLACE OF DEATH

County Christian

Township Lincoln

or Village _____

City _____ (NO _____ St. _____ Ward _____)

Registration District No. 182

Primary Registration District No. 5252

File No. 16525 ✓

Registered No. 26

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

FULL NAME Joe Gham

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED S. (Write the word)

DATE OF BIRTH May 10, 1912 (Month) (Day) (Year)

AGE _____ If LESS than 1 day, hrs. or mins. _____ yrs. _____ mos. _____ ds.

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

BIRTHPLACE (City or town, State or foreign country) Clermont, Mo.

PARENTS NAME OF FATHER Joe Gham BIRTHPLACE OF FATHER Mo. MAIDEN NAME OF MOTHER Joe Jones BIRTHPLACE OF MOTHER Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W.A. Maples ✓

(ADDRESS) Clermont May 11, 1912 T.R. Appleby REGISTRAR ✓

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 10, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 10, 1912, to May 10, 1912, that I last saw him alive on May 10, 1912, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Poor circulation (Duration) _____ yrs. _____ mos. 20 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) A.A. Maples M. D. 1912 (Address) Clermont

*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 Lugs Chapel DATE OF BURIAL May 11, 1912 UNDERTAKER Sam Frazier ADDRESS Boyer

WRITING PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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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.)