

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**

PLAGE OF DEATH Cooper  
County Cooper  
Township Atterville  
or  
Village  
or  
City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 22/ File No. 16621  
53028  
Primary Registration District No. 4733 Registered No. \_\_\_\_\_

FULL NAME John P. Adam

(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 <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> (Write the word)	DATE OF DEATH <u>May 15</u> , 19 <u>12</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>FEB. 5</u> , 18 <u>40</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>May 6</u> , 19 <u>12</u> , to <u>May 15</u> , 19 <u>12</u> , that I last saw him alive on <u>May 7</u> , 19 <u>12</u> , and that death occurred, on the date stated above, at <u>2:45</u> p.m.	
AGE <u>72</u> yrs. <u>3</u> mos. <u>10</u> ds.		If LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Stroke Paralysis</u>	
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>-</u>			(Duration) _____ yrs. _____ mos. <u>9</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Missouri</u>			Contributory <u>Heart &amp; Kidney disease</u> (SECONDARY) <u>about 3</u> yrs. _____ mos. _____ ds. (Duration)	
PARENTS	NAME OF FATHER <u>Scott Kew</u>	(Signed) <u>T. L. Fogle</u> M. D. 19 <u>12</u> (Address) <u>Atterville Mo</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scott Kew</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>Scott Kew</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Scott Kew</u>	At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter Wear</u> (ADDRESS) <u>Atterville</u>			Where was disease contracted if not at place of death? Former or usual residence.	
Filed <u>May 24</u> , 19 <u>12</u> <u>T. L. Fogle</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Pleasant Green</u>	DATE OF BURIAL <u>5/16</u> , 19 <u>12</u>
			UNDERTAKER <u>Otterville Fuel Co</u>	ADDRESS <u>Atterville</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*, *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 septichaemia," "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.)



## PLACE OF DEATH

County Cooper  
 Township Olterville  
 or  
 Village  
 or  
 City (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

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

 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

Registration District No. 221 File No. 16621  
 Primary Registration District No. 5302 B Registered No. \_\_\_\_\_

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

FULL NAME John T. Adams

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>wd.</u>
DATE OF BIRTH <u>Feb. 5</u> , 18 <u>40</u> (Month) (Day) (Year)		
AGE <u>72</u> yrs. <u>3</u> mos. <u>10</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)		

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

PARENTS	NAME OF FATHER <u>Walter Mear</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>
	MAIDEN NAME OF MOTHER <u>Wm.</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Mear  
 (ADDRESS) Olterville Mo

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 15, 1912  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from  
May 6, 1912, to May 15, 1912,  
 that I last saw him alive on May 7, 1912,  
 and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH\* was as follows:  
Paralysis - Central  
Cereb. of Harvey Hooper with  
Hemiplegia  
Contributory Heart & Kidney disease  
 (SECONDARY)  
 (Duration) abt 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Signed, Walter L Fogle M. D. X  
May 16, 1912 (Address) Olterville 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 Pleasant Green DATE OF BURIAL May 16, 1912

UNDERTAKER Olterville Bur. Co. ADDRESS Olterville Mo

Original file, date \_\_\_\_\_, 19\_\_\_\_

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

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.

SUPPLEMENTARY

Filed May 24, 1912 Walter L Fogle REGISTRAR  
 MAY

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Association]

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