

MARGIN RESERVED FOR BINDING

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 St. Francois
Township _____
or
Village Farmington
or
City _____ (NO. _____) St. _____ Ward _____

Registration District No. 773 File No. 18111
Primary Registration District No. 4464 Registered No. 147

FULL NAME George Walker

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (If wife the widow) Single

DATE OF BIRTH _____ 1877
(Month) (Day) (Year)

AGE 35 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work None
(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 Don't know

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

MAIDEN NAME OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) State Hospital # 4

(ADDRESS) Farmington Mo.

Filed May 12/1912 C. R. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 15, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8-15, 1911, to May 12, 1912, that I last saw him alive on May 11, 1912, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:
Tuberculosis
23A

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

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

(Signed) J. P. Miller M. D. 5-16, 1912 (Address) Farmington 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 8 yrs. 17 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? Former or usual residence Hellboro Mo.

PLACE OF BURIAL OR REMOVAL Potosi DATE OF BURIAL May 13/1912

UNDERTAKER Yang & Bro. ADDRESS Farmington

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.)



PLACE OF DEATH

County

St. Francois

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

Township

Registration District No.

773

File No.

Village

Primary Registration District No.

4464

Registered No.

147

City

Farmington

(NO.

St.

Ward)

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

FULL NAME

George Naska

PERSONAL AND STATISTICAL PARTICULARS

SEX

m

COLOR OR RACE

*w*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*s*

DATE OF BIRTH

(Month)

(Day)

(Year)

AGE

35

yrs.

mos.

ds.

IF LESS than
1 day, hrs.
or mins.

OCCUPATION

(a) Trade, profession, or particular kind of work

none

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

BIRTHPLACE

(City or town, State or foreign country)

no

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May 12

(Month)

(Day)

191*2*
(Year)

I HEREBY CERTIFY, that I attended deceased from

April 15, 191*2*, to *May 12*, 191*2*,that I last saw him alive on *May 12*, 191*2*,and that death occurred, on the date stated above, at *4:30* p.m.

The CAUSE OF DEATH* was as follows:

Inter atherosclerosis of lungs

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. A. Tiller

M. D.

*May 18*191*2*

(Address)

Farmington 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.

8 mos.*17* ds.

In the State

yrs.

mos.

ds.

Where was disease contracted if not at place of death?

Former or usual residence

Wellsboro New.

PLACE OF BURIAL OR REMOVAL

Potosi

DATE OF BURIAL

May 13, 191*2*

UNDERTAKER

Ling & Bros.

ADDRESS

Farmington

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

State Hosp # 4

(ADDRESS)

Farmington Mo.

Med

*July 10*191*2**E. R. Flewelling*

REGISTRAR

Original file, date

MAY

19

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

WRITE PL. LY. WITH ONE ADI.

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[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.)

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