

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS		
County	Lincoln		Registration District No.	486	
Township	American		Primary Registration District No.	5649	
or					
Village					
or					
City					
FULL NAME			ROBERT SALES		
PERSONAL AND STATISTICAL PARTICULARS:			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
Male		Single	July 4 th	1912	
DATE OF BIRTH:			I HEREBY CERTIFY, that I attended deceased from		
June 4, 1912			, 191, to , 191,		
AGE	1 month		that I last saw him alive on July 4 th , 1912,		
	1 yrs. 7 mos. ds.		and that death occurred, on the date stated above, at 3 P. M.		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
(a) Trade, profession, or particular kind of work			198 Pneumonia		
(b) General nature of industry, business, or establishment in which employed (or employer)	O		Labor		
BIRTHPLACE	Lincoln Co		Contributory		
(City or town, State or foreign country)			(SECONDARY)		
PARENTS	NAME OF FATHER		(Duration) yrs. mos. ds.		
	John Laird		Signed D. V. Keeling M. D.		
	BIRTHPLACE OF FATHER		July 4, 1912 (Address) Elsberry Mo		
	(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.		
	MAIDEN NAME OF MOTHER		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	Minnie Bellinger		At place of death yrs. mos. ds. In the State yrs. mos. ds.		
	BIRTHPLACE OF MOTHER		Where was disease contracted if not at place of death?		
	Lincoln Co		Former or usual residence		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			PLACE OF BURIAL OR REMOVAL		
(Informant)	B. H. Wells		Elsberry, Mo.		
(ADDRESS)	Elsberry, Mo.		DATE OF BURIAL		
Filed July 10, 1912	C. E. Powell		July 5th, 1912		
	REGISTRAR		ADDRESS		
			Elsberry, Mo.		

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

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.)



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PLACE OF DEATH

County Lincoln
 Township Hurricane
 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. 486 File No. 23495-17
 Primary Registration District No. 5649 Registered No. _____

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

FULL NAME Roy Laird

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(#Write the word)

DATE OF BIRTH June 4, 1912
(Month) (Day) (Year)

AGE 1 yrs. 1 mos. ds. If LESS than 1 day, _____ hrs. _____ 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) Lincoln Co.

PARENTS NAME OF FATHER John Laird BIRTHPLACE OF FATHER Ill.
 MAIDEN NAME OF MOTHER Wynnie Belcher BIRTHPLACE OF MOTHER Lincoln Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) B.H. Wells
 (ADDRESS) Elsherry Mo.

Filled July 10, 1912 by C.E. Powell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 4, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on July 4, 1912, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:
Pneumonia
tobac
 (Duration) _____ yrs. _____ mos. 3 ds.

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

(Signed) F. V. Keeling M. D. July 4, 1912 (Address) Elsherry 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 Elsherry Mo. DATE OF BURIAL July 5, 1912

UNDERTAKER E. S. Morris ADDRESS Elsherry Mo.

Revised United States Standard Certificate of Death

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

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