

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 St. Francois ✓  
County St. Francois  
Township St. Francois Registration District No. 274 File No. 24041  
or  
Village \_\_\_\_\_ Primary Registration District No. 4465 Registered No. 24141  
or  
City Flask River (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Willie Skoudiak

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Infant</u>	DATE OF DEATH <u>July 12</u> , 191 <u>2</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>June 20</u> , 191 <u>2</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,	
AGE <u>—</u> yrs. <u>—</u> mos. <u>21</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?	that I last saw him alive on <u>July 1</u> , 191 <u>2</u> ,	
OCCUPATION (a) Trade, profession, or particular kind of work <u>—</u>			and that death occurred, on the date stated above, at <u>10 P.</u> m.	
(b) General nature of industry, business, or establishment in which employed (or employer) <u>— 0</u>			The CAUSE OF DEATH* was as follows: <u>Inanition</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Flat River Mo.</u>			<u>159</u> <u>161</u> (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER <u>Joseph Skoudiak</u>		Contributory (SECONDARY) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Austria</u>		(Signed) <u>F. L. Keith</u> M. D.	
	MAIDEN NAME OF MOTHER <u>Matilda Lepka</u>		<u>July 13</u> , 191 <u>2</u> (Address) <u>Flat River</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Austria</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Rella Cozear</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
(ADDRESS) <u>Flat River Mo.</u>			Where was disease contracted If not at place of death? Former or usual residence _____	
Filed <u>7/12</u> , 191 <u>2</u>			PLACE OF BURIAL OR REMOVAL <u>St. Joseph Mo.</u>	
REGISTRAR _____			DATE OF BURIAL <u>July 13</u> , 191 <u>2</u>	
			UNDERTAKER <u>Joseph Rieck</u>	
			ADDRESS <u>Flat River Mo.</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 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.)



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

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CERTIFICATE OF DEATH

PLACE OF DEATH  
County St. Francois  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Flat River NO. \_\_\_\_\_

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

Registration District No. 774 File No. \_\_\_\_\_  
Primary Registration District No. 4465 Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Willie Skondiak

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH June 20, 1912  
(Month) (Day) (Year)

AGE \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 21 ds.

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) Flat River Mo.

PARENTS NAME OF FATHER Joseph Skondiak BIRTHPLACE OF FATHER (City or town, State or foreign country) Austria MAIDEN NAME OF MOTHER Matilda Lepka BIRTHPLACE OF MOTHER (City or town, State or foreign country) Austria

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Rolla Cozear (ADDRESS) Flat River Mo.

Filed 8/1 1912 M. H. Tappan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 12, 1912  
(Month) (Day) (Year)

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

The CAUSE OF DEATH\* was as follows: Exhaustion  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Signed) F. L. Keith M. D. July 13, 1912 (Address) Flat River 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 De Sloge Mo. DATE OF BURIAL July 23, 1912 UNDERTAKER Henry Rinke ADDRESS Flat River Mo.

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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 *septicæmia*," "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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