

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			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Wright</i>	Registration District No.	<i>911</i>	File No.	<i>25317 3517</i>
Township	<i>Montgomery</i>	Primary Registration District No.	<i>6227</i>	Registered No.	<i>17</i>
or Village	<i>Astoria</i>	City	(NO. _____ St.; _____ Ward)	[If death occurred in a hospital or institution, give its NAME instead of street and number]	
FULL NAME <i>Wm B. Shaw</i>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	<del>SINGLE</del> MARRIED <i>Married</i> <del>WIDOWED</del> <del>OR DIVORCED</del> (Write the word)	DATE OF DEATH <i>July 26,</i> 191 <i>2</i> (Month) (Day) (Year)		
DATE OF BIRTH	<i>Feb 4 1850</i> <i>July 26 1912</i> (Month) (Day) (Year)		I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,		
AGE	<i>62</i> yrs. <i>5</i> mos. <i>15</i> ds.		that I last saw h _____ alive on _____, 191____,		
OCCUPATION	<i>Farmer</i>		and that death occurred, on the date stated above, at <i>2:15</i> p.m.		
(a) Trade, profession, or particular kind of work	<i>Farming</i>		The CAUSE OF DEATH* was as follows: <i>Tuberculosis of lungs</i>		
(b) General nature of industry, business, or establishment in which employed (or employer)	<i>Farming</i>		<i>23rd</i>		
BIRTHPLACE (City or town, State or foreign country)	<i>Grandy Co Tenn</i>		(Duration) _____ yrs. _____ mos. _____ ds.		
PARENTS	NAME OF FATHER	<i>Saml Shaw</i>		Contributory (SECONDARY)	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	<i>Tenn</i>		(Duration) _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER	<i>Bea</i>		(Signed) _____ M. D.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<i>Tenn</i>		_____, 191____ (Address) _____	
*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					
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 <i>Astoria Mo</i>					
PLACE OF BURIAL OR REMOVAL					
DATE OF BURIAL					
<i>Green mtn ave 7 27 1912</i>					
UNDERTAKER					
ADDRESS					
<i>W W Daggell Astoria Mo</i>					
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <i>Henry Shaw</i>					
(ADDRESS) <i>Astoria</i>					
Filed <i>7/26 1912</i>					
REGISTRAR					

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

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Wright  
Township Montgomery  
or  
Village  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 911 File No. 25317  
Primary Registration District No. 6227 Registered No. \_\_\_\_\_

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

FULL NAME Wm B. Shaw

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb. 11, 1850  
(Month) (Day) (Year)

AGE 62 yrs. 5 mos. 15 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

BIRTHPLACE (City or town, State or foreign country) Groundy Co. Tenn.

PARENTS  
NAME OF FATHER Sam'l Shaw  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.  
MAIDEN NAME OF MOTHER Lucinda Burr  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Wm Henry Shaw  
(ADDRESS) Astoria Mo.

Filed July 26, 1912 Geo R. Crisp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 26, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_;

that death occurred, on the date stated above, at 2:15 p.

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

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Dr. E. L. Evans M. D.  
July 24, 1912 (Address) Manes, 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 Green Mt. Cem. DATE OF BURIAL 7-27, 1912

UNDERTAKER W. W. Daggett ADDRESS Astoria Mo.

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(Approved by U. S. Census and American Public Health  
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