

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 Barton  
 County Barton  
 Township Union  
 or Union  
 Village Mudon Mines  
 or Mudon Mines  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 Registration District No. 42 File No. 25389  
 Primary Registration District No. 4626 Registered No. 12  
 FULL NAME Urie Decker

(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>M</u>	COLOR OR RACE: <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): <u>Married</u>	DATE OF DEATH: <u>8/16</u> , 191 <u>2</u> (Month) (Day) (Year)		
DATE OF BIRTH: <u>10</u> <u>15</u> , 188 <u>1</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>8/16</u> , 191 <u>2</u> , to <u>8/16</u> , 191 <u>2</u> , that I last saw him alive on <u>8/15</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>4 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Accidental</u>		
AGE: <u>30</u> yrs. <u>10</u> mos. <u>1</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	Contributory (Secondary): <u>173</u> <u>194B</u> (Duration) <u>2</u> yrs. <u>6</u> mos. <u>4</u> ds. <u>Concussion Brain</u>		
OCCUPATION (a) Trade, profession, or particular kind of work: <u>Coal Miner</u> (b) General nature of industry, business, or establishment in which employed (or employer): <u>Mining</u> 5-28			(Signed) <u>J.P. Link</u> M. D. <u>8/17</u> , 191 <u>2</u> (Address) <u>Mudon Mines</u>		
BIRTHPLACE (City or town, State or foreign country): <u>Ind.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
PARENTS	NAME OF FATHER: <u>William Decker</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country): <u>Ind.</u>		Where was disease contracted if not at place of death? _____		
	MAIDEN NAME OF MOTHER: <u>8</u>		Former or usual residence: _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country): <u>Ind.</u>		PLACE OF BURIAL OR REMOVAL: <u>Palestine Ill</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			DATE OF BURIAL: <u>8/19</u> , 191 <u>2</u>		
(Informant): <u>Caris Decker Bro.</u>			UNDERTAKER: <u>M. G. Gorrell</u>		
(ADDRESS): <u>Effingham Ind.</u>			ADDRESS: <u>Pittsburg Mo</u>		
Filed <u>8/17</u> , 191 <u>2</u> <u>J.P. Link MD</u>			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.)



MARGIN RESERVED FOR BINDING

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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Barton

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

Township \_\_\_\_\_ Registration District No. 42 File No. 25389

Village Minden Mines Primary Registration District No. 4024 Registered No. 12

City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Wrie Decker

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED married (Write the word)

DATE OF BIRTH 10 - 15, 1881 (Month) (Day) (Year)

AGE 30 yrs. 10 mos. 1 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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

PARENTS NAME OF FATHER William Decker BIRTHPLACE OF FATHER (City or town, State or foreign country) K MAIDEN NAME OF MOTHER K BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Caris Decker (ADDRESS) Effingham Ind.

Filed 10/5 1912 Ypp Yish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8 - 16, 1912 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 8 - 16, 1912, to 8 - 16, 1912, that I last saw him alive on 8 - 15, 1912

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH\* was as follows: Accidental, killed by fall of rock

(Duration) yrs. mos. ds.

Contributory Concussion of brain (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Ypp Yish M. D. 8/17 1912 (Address) Minden Mines

\*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 Palestine Ill. DATE OF BURIAL 8/17 1912

UNDERTAKER M.A. Gorrell ADDRESS Pittsburg Mo.

Original file, date Aug-8/17 1912 All information called for must be written on this Supplementary Certificate.

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