

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

County

Butler

Township

or

Village

or

City

Papier Bluff

(No.)

Registration District No.

Primary Registration District No.

(No.) 245 N E

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No.

25550

Registered No.

164

St.: Ward)

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

FULL NAME

John Dawson

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(If write the word)

Single

DATE OF BIRTH

Nov 1

(Month)

1909

- (Day)

(Year)

AGE

2

yrs.

8

mos.

ds.

If LESS than

1 day, ___ hrs.

or ___ 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)

Leaper Mo

NAME OF FATHER

O. D. Dawson

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Jasper Ohio

MAIDEN NAME OF MOTHER

Martha Munk

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Wayne Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. D. Dawson

(ADDRESS)

Papier Bluff Mo

Filed

Aug 2 1912

2

Aminia Clark

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug 1

(Day)

1912

(Year)

I HEREBY CERTIFY, that I attended deceased from

June 30, 1912, to Aug 1, 1912,

that I last saw him alive on July 31, 1912,

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Septic meningitis

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

J. M. D. Sawyer

Aug 1, 1912 (Address) Papier Bluff 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

Leaper Mo

DATE OF BURIAL

Aug 2, 1912

UNDERTAKER

Frank L. L. L.

ADDRESS

P. B.

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*, *Sarcoma*, 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 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.)

PLACE OF DEATH

County Butler

Township _____

or _____

Village _____

or _____

City Poplar Bluff

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. 89File No. 25550Primary Registration District No. 3007Registered No. 164

St. _____ Ward _____

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

FULL NAME

John Dawson

PERSONAL AND STATISTICAL PARTICULARS

SEX

male

COLOR OR RACE

whiteSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)Single

DATE OF BIRTH

Nov. 1, 1909
(Month) (Day) (Year)

AGE

2 yrs 8 mos. ds.IF LESS than
1 day, _____ hrs.
or _____ 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)

Leeper Mo.

NAME OF FATHER

O. W. Dawson

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Jasper Ohio

MAIDEN NAME OF MOTHER

Martha Mark

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Wayne Co. Mo.

THE [ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. W. Dawson

(ADDRESS)

Poplar Bluffs, Mo.

Filed

Oct 9, 1912A. P. Gray

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug. 1, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

June 30, 1912, to Aug. 1, 1912,that I last saw him alive on July 31, 1912,and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Septo meningitis
Tubercular

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

Contributory

(SECONDARY)

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

(Signed)

John W. Seybold M. D.
Aug. 1, 1912 (Address) Poplar Bluffs, 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. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted
If not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

Leeper, Mo.

DATE OF BURIAL

Aug. 2, 1912

UNDERTAKER

Frank F & U. Co. Poplar Bluffs

ADDRESS

Poplar BluffsOriginal file, date Aug, 19____

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

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.

Revised United States Standard Certificate of Death

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

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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*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

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