

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Butter</i>		Registration District No.	<i>1089</i>	
Township	<i>Cane Creek</i>		Primary Registration District No.	<i>5136</i>	
Village			Registered No.	<i>2</i>	
City	(NO. _____) _____		St.	Ward	
FULL NAME			<i>Albert Walton</i>		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH		
<i>Male</i>	<i>White</i>	<i>Single</i>	<i>Aug. 15, 1912</i>		
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from		
<i>Feb. 1, 1910</i>			<i>Aug. 7, 1912, to Aug. 15, 1912,</i>		
AGE			that I last saw him alive on <i>Aug. 11, 1912,</i>		
<i>2 yrs. 4 mos. 16 ds.</i>			and that death occurred, on the date stated above, at <i>4 P. M.</i>		
OCCUPATION			The CAUSE OF DEATH* was as follows:		
<i>Infant</i>			<i>Dysentery</i>		
BIRTHPLACE			<i>38</i>		
<i>Butter Co., Mo.</i>			<i>176 B 105</i>		
NAME OF FATHER			Contributory <i>Intermittent Fever</i>		
<i>W. L. Walton</i>			(Duration) _____ yrs. _____ mos. <i>10</i> ds.		
BIRTHPLACE OF FATHER			(Signed) <i>Dr. McPherson</i> M. D.		
<i>Butter Co., Mo.</i>			<i>Aug. 15, 1912</i> (Address) <i>Ellimore, Mo.</i>		
MAIDEN NAME OF MOTHER			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
<i>Lovie Macey</i>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
BIRTHPLACE OF MOTHER			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
<i>Butter Co., Mo.</i>			Where was disease contracted if not at place of death? _____		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			Former or usual residence _____		
(Informant) <i>W. L. Walton</i>			PLACE OF BURIAL OR REMOVAL		
(ADDRESS) <i>Ellimore</i>			<i>Ellimore Merc Co</i>		
Filed <i>Aug 16 1912</i>			DATE OF BURIAL		
<i>J. B. Caudaly</i> REGISTRAR			<i>Aug 16 1912</i>		
			ADDRESS		
			<i>Ellimore Mo</i>		

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.)



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

PLACE OF DEATH

County Butler
 Township Cane Creek
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1089 File No. 25368
 Primary Registration District No. 5136 Registered No. 2

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

FULL NAME Albert Walton

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Feb, 1, 1910
 (Month) (Day) (Year)

AGE 2 yrs. 6 mos. 15 ds. If LESS than 1 day, hrs. or mins.

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

BIRTHPLACE (City or town, State or foreign country) Butler Co. Mo.

PARENTS NAME OF FATHER W. L. Walton BIRTHPLACE OF FATHER Butler Co. Mo.
 MAIDEN NAME OF MOTHER Rovie Macey BIRTHPLACE OF MOTHER Butler Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. L. Walton
 (ADDRESS) Ellsinore, Mo.

Filed July 16, 1912 J. B. Sweeney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 15, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 7, 1912, to Aug. 15, 1912, that I last saw him alive on Aug. 11, 1912

and that death occurred, on the date stated above, at 6 p. m.

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

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

(Signed) N. C. McPherson M. D. (Address) Ellsinore, Mo.
Aug. 15, 1912

*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 Ellsinore, Mo. DATE OF BURIAL Aug. 16, 1912

UNDERTAKER Shiloh ADDRESS Ellsinore, Mo.

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