

OF HEALTH
TISTICS

PLACE OF DEATH

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

County Stone
Township Washington
or
Village ~~Galena~~
or
City ✓ (NO. _____) (St. _____) (Ward _____)

Registration District No. 843 File No. 28431

Primary Registration District No. 6/06 Registered No. 10

FULL NAME Henry C. Hampshire

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH July 27, 1842
(Month) (Day) (Year)

AGE 70 yrs. ✓ mos. 25 ds. If LESS than 1 day, ✓ hrs. or ✓ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

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

PARENTS
NAME OF FATHER Dont Know
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont Know
MAIDEN NAME OF MOTHER Dont Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont Know

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Significant) Jones S. Coleman

(ADDRESS) Galena Mo.

1912
Aug 22, 1912 J. M. Good

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 22, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 16, 1912, to Aug 22, 1912, that I last saw him alive on Aug 21, 1912, and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:

Dysentery
130 14

(Duration) ✓ yrs. ✓ mos. 6 ds.
Contributory ✓
(SECONDARY) (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) L. Henson M. D. Aug. 22, 1912 (Address) Galena 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 1 yrs. 7 mos. 27 ds. In the State 13 yrs. ✓ mos. ✓ ds.
Where was disease contracted if not at place of death? Place of death
Former or usual residence Arkansas

PLACE OF BURIAL OR REMOVAL Galena Mo DATE OF BURIAL Aug 23, 1912

UNDERTAKER None ADDRESS _____

ONLY WITH UNFADIN (N) TIES I A PERMANENT RECORD

Information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state in what terms, and the patient may be properly classified as follows: (a) Violent Causes, (b) Non-Violent Causes, (c) Accidental, (d) Suicidal, (e) Homicidal, (f) Unknown.

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

PLACE OF DEATH

County _____
 Township _____ Registration District No. _____ File No. _____
 or _____
 Village _____ Primary Registration District No. _____ Registered No. _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (<i>Write the word</i>)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ 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) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____, 191____, REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attend _____, 191____, to _____
 that I last saw h_____ alive on _____
 and that death occurred, on the date stated
The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____

_____ (Duration) _____ yrs. _____

Contributory
 (SECONDARY) _____

(Signed) _____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTES, AND RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yr.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DA _____

UNDERTAKER _____ AD _____

DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebral meningitis, Typhoid pneumonia, unqualified, is indefinite; Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of _____ (name organ; "Cancer" is less definite; avoid

FILE TO VITAL STATISTICS
 (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12) (13) (14) (15) (16) (17) (18) (19) (20) (21) (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33) (34) (35) (36) (37) (38) (39) (40) (41) (42) (43) (44) (45) (46) (47) (48) (49) (50) (51) (52) (53) (54) (55) (56) (57) (58) (59) (60) (61) (62) (63) (64) (65) (66) (67) (68) (69) (70) (71) (72) (73) (74) (75) (76) (77) (78) (79) (80) (81) (82) (83) (84) (85) (86) (87) (88) (89) (90) (91) (92) (93) (94) (95) (96) (97) (98) (99) (100)

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Stone
Township Washington

Registration District No. 843 File No. 28431
Primary Registration District No. 6106 Registered No. 10

FULL NAME Henry C. Hampshire

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

DATE OF DEATH Aug. 22, 1912
(Month) (Day) (Year)

DATE OF BIRTH July 27, 1842
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 16, 1912, to Aug. 22, 1912 that I last saw him alive on Aug. 21, 1912 and that death occurred, on the date stated above, at 10 a.m.

AGE 70 yrs. 25 mos. 25 ds. If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH was as follows:

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

Dysentery
(Duration) yrs. mos. 6 ds.

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

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

NAME OF FATHER Samuel Coleman

(Signed) L. Henson M. D.
Aug. 22, 1912 (Address) Galena, Mo.

BIRTHPLACE OF FATHER (City or town, State or foreign country)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER Unknown

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

[ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death?

(Signant) Samuel Coleman
(ADDRESS) Galena, Mo.

Former or usual residence

Filed Aug 22 1912 T. J. McComb REGISTRAR

PLACE OF BURIAL OR REMOVAL Galena, Mo. DATE OF BURIAL Aug 23 1912

UNDERTAKER None ADDRESS

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*, *Composer*, *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 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.)