

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
County Oregon
Township _____
or
Village Koshkonoong, Mo.
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 631 File No. 30316
Primary Registration District No. 4381 Registered No. 39

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

FULL NAME Eral Thomas Rice

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>July 12, 1912</u> (Month) (Day) (Year)		
AGE <u>2 yrs. 21 ds.</u>		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) Koshkonoong, Mo.

NAME OF FATHER Thomas Rice

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

MAIDEN NAME OF MOTHER Ida Huffman

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Oregon Co., Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Informant: Ida Huffman
Patricia
(ADDRESS) Koshkonoong, Mo.

Filed Sept 24, 1912 W. C. Amerman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 21, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,
and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Child never well. Did not grow any from birth. Hereditary Tuberculosis. No Physician called.

Contributory
(SECONDARY) _____
(Signed) No Physician called M. D.
_____, 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.

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 Mount Kabor DATE OF BURIAL Sept 22, 1912

UNDERTAKER W. C. Amerman ADDRESS Koshkonoong, Mo.

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**

County.....
 Township..... File No.....
 or.....
 Village..... Registration District No.....
 or.....
 City.....(NO.....St.:.....Ward)
 Registered No.....
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE	DATE OF BIRTH
		MARRIED	
		OR DIVORCED	
		(If <i>fit</i> the word)	
		(Month)....., 191....., (Day)....., 191..... (Year)	
AGE		IF LESS than 1 day,.....hrs. or.....min.?	
	yrs.,.....mos.,.....ds.	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH....., 191..... (Month)....., 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from
; 191....., to....., 191.....
 that I last saw h..... alive on....., 191.....
 and that death occurred, on the date stated above, at.....m.
 The CAUSE OF DEATH* was as follows:

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

Contributory
 (SECONDARY)

(Signed)....., 191..... (Address)..... M. D.
 (Duration).....yrs.,.....mos.,.....ds.
 (Duration).....yrs.,.....mos.,.....ds.

*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	DATE OF BURIAL
UNDERTAKER	ADDRESS

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

PLACE OF DEATH

County Oregon

Township or Village or City Koshkonong

Registration District No. 631

File No. _____

Primary Registration District No. 4381

Registered No. 32

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

FULL NAME Eral Thomas Rice

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white
 DATE OF BIRTH July 1, 1912
 AGE 2 yrs. 2 mos. 21 ds.

DATE OF DEATH Sept. 21, 1912
 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

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

The CAUSE OF DEATH* was as follows:
Child never well. Did not grow any from birth. Hereditary tuberculosis. No physician

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

NAME OF FATHER Thomas Rice
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Massfield, Mo.
 MAIDEN NAME OF MOTHER Ida Huffman
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Oregon Co. Mo.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Address) _____ M. D.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Ida Huffman
 (ADDRESS) Koshkonong, 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 _____

Filed Sept 24 1912 W.C. Amerman REGISTRAR

PLACE OF BURIAL OR REMOVAL Mount Nebo DATE OF BURIAL Sept. 22, 1912
 UNDERTAKER W.C. Amerman ADDRESS Koshkonong

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

TEMPORARY

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, peritonaeum*, 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.)

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Mr. Frank B. Hiller, M.D.

State Registrar

Dear Sir

I return to you supplementary Report I have signed it as I did the original one sent, as to a Physicians signature It can not be had because there was no Physician there, and the Father and the mother both dead I have given you all there is to it.

Respectfully Yours -

W. C. Amernan

Local Registrar, 631.

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