

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

Dr Elkins. MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Green

Township _____

Registration District No. 318

File No. 32668

or Village _____

Primary Registration District No. 2001

Registered No. 541

or City Springfield (NO. _____)

St.; _____ Ward _____

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

FULL NAME Robert Lee Fallin

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX MALE FEMALE
COLOR OR RACE 1
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Oct 13, 1922
(Month) (Day) (Year)

DATE OF BIRTH March 4, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 29, 1922, to Oct 13, 1922, that I last saw him alive on Oct 13, 1922,

AGE _____ yrs. 7 mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

and that death occurred, on the date stated above, at 10³⁰ a.m.

OCCUPATION, (a) Trade, profession, or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer) 0

The CAUSE OF DEATH* was as follows:
Chronic Colitis
117B
10A
104

BIRTHPLACE (City or town, State or foreign country) Springfield

About 2 months (Duration) yrs. _____ mos. _____ ds.

NAME OF FATHER Albert Fallin

Contributory Purpura Haemorrhagica (SECONDARY) (Duration) yrs. _____ mos. 3 ds.

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

(Signed) C. H. King M. D.
1914 (Address) 318 Leary St.

MAIDEN NAME OF MOTHER Susie King

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

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) J. H. King
(ADDRESS) 1208 Olive.

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

Former or usual residence _____

Filed Oct 14, 1922 Wilbur Smith REGISTRAR

PLACE OF BURIAL OR REMOVAL Maple Park. DATE OF BURIAL Oct 14, 1922

UNDERTAKER W. C. Lowmyer ADDRESS 305 W. Walnut

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*, *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.)



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MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Greene
Township _____
or
Village _____
or
City Springfield (NO. _____)

Registration District No. 318
Primary Registration District No. 2001

File No. 32668 ✓
Registered No. 541

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

FULL NAME Robert Lee Fallin

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 4, 1912
(Month) (Day) (Year)

AGE 7 yrs. 7 mos. ds. IF LESS than 1 day, hrs or min.?

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) Springfield

PARENTS
NAME OF FATHER Albert Fallin
BIRTHPLACE OF FATHER Ark.
MAIDEN NAME OF MOTHER Naze King
BIRTHPLACE OF MOTHER Miss Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. King
(ADDRESS) 1208 Olive Springfield

Filed Oct 14 1912 W. C. Schmeyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 13, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 29, 1912, to Oct 13, 1912, that I last saw him alive on Oct 13, 1912, and that death occurred, on the date stated above, at 1030 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Colitis

Contributory about 2 months
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) C. B. Elkins M.D.
10-14, 1912 (Address) 318 College St.

*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 Maple Park DATE OF BURIAL Oct. 14, 1912

UNDERTAKER W. C. Schmeyer ADDRESS 305 W. Main

Revised United States Standard Certificate of Death

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

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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 "*Asihenia*," "*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 septichaemia*," "*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.)