

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 Holt
Township Minion or Village _____
City _____ (NO. _____) St. _____ Ward _____
Registration District No. 947 File No. 182790
Primary Registration District No. 5512 Registered No. 17

FULL NAME Ernest Edward Roland

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED <u>single</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Dec 4</u> , 191 <u>1</u> (Month) (Day) (Year)		
AGE <u>11</u> yrs. <u>1</u> mos. <u>1</u> 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) _____		
PARENTS	NAME OF FATHER <u>William Roland</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>West Co Mo</u>	
	MAIDEN NAME OF MOTHER <u>Grace Roland</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>White Cloud Kans</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 5, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 5, 1912, to Oct 5, 1912, that I last saw him alive on Oct 5, 1912, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough
9
10-7-12
(Duration) yrs. mos. ds.
Contributory Pneumonia
(SECONDARY) (Duration) yrs. mos. ds.
(Signed) J. Estoyan M. D.
Oct 6, 1912 (Address) J Estoyan

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Roland
(ADDRESS) Mapier Mo

Filed Oct 10, 1912 J. Z. Minton, Reg
REGISTRAR

PLACE OF BURIAL OR REMOVAL

Boyd Cemetery
UNDERTAKER
W. Roland

DATE OF BURIAL

Oct 6, 1912
ADDRESS
Mapier Mo

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, 8 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.)

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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.

PLACE OF DEATH
 County Holt
 Township _____ Registration District No. 947 File No. 321790
 or _____ Primary Registration District No. 5512 Registered No. 17
 Village _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Ernie Edward Noland

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single
 DATE OF BIRTH Dec. 4, 1911
 (Month) (Day) (Year)
 AGE 11 yrs. 1 mos. 1 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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 5, 1912
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Oct. 5, 1912, to Oct. 5, 1912, that I last saw him alive on Oct. 5, 1912, and that death occurred, on the date stated above, at 5 p. m.
 The CAUSE OF DEATH* was as follows:
Whooping cough

BIRTHPLACE (City or town, State or foreign country) Holt Co. Mo.
 PARENTS
 NAME OF FATHER William Noland
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Holt Co.
 MAIDEN NAME OF MOTHER Grace Noland
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) White Cloud Kans.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.
 Signed F. G. Logan M. D. Oct. 6, 1912 (Address) Napier, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs Noland
 (ADDRESS) Napier, Mo.
 Filed Oct 10 1912 J. L. Weston REGISTRAR

PLACE OF BURIAL OR REMOVAL Boyd Cemetery DATE OF BURIAL Oct. 6, 1912
 UNDERTAKER Wm. Noland ADDRESS Napier, Mo.

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 "*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.)