

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

County

maries

Township

Dry creek

or

Village

or

City

(NO.

St.

Ward)

Registration District No.

1022

File No.

33487

Primary Registration District No.

5732

Registered No.

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

FULL NAME

No Name

PERSONAL AND STATISTICAL PARTICULARS

SEX

female

COLOR OR RACE

white

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

DATE OF BIRTH

Oct. 8th

(Month)

(Day)

(Year)

AGE

yrs. 8 mos. 8 ds.

If LESS than

1 day, hrs.

or min.?

OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

BIRTHPLACE

(City or town,

State or foreign country)

Dry creek, maries c.

PARENTS

NAME OF FATHER

John Brumby

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Phelps c. mo

MAIDEN NAME OF MOTHER

Ellen Copeland

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

maries c. mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. M. Copeland

(ADDRESS)

Hayden mo

Filed

Oct 10

191

Peter Perry

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Oct. 8th

(Month)

(Day)

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.

The CAUSE OF DEATH* was as follows:

Child was between 6 + 7 mo.

157

(Duration)

yrs.

mos.

ds.

Contributory

(SECONDARY)

(Duration)

yrs.

mos.

ds.

(Signed)

W. A. Von Grunp

M. D.

Oct 8

1912

(Address)

Ligon 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

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

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, 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, 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 "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 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.)

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. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONAL history important.

PLACE OF DEATH		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County	<i>Marion</i>	REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.	File No. <i>V</i>
Township or Village or City	<i>dry Creek</i>	Registration District No. <i>1022</i>	Registered No. _____
		Primary Registration District No. <i>5732</i>	
	(NO. _____) St. _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number]
FULL NAME		<i>no name</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>female</i>	<i>white</i>		<i>Oct. 8</i> , 191 <i>2</i>
DATE OF BIRTH		(Month) (Day) (Year)	
<i>Oct. 8</i> , 191 <i>2</i>			
AGE		I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ a.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:	
<i>none</i>		<i>Child was between 6 and 7 months.</i>	
BIRTHPLACE (City or town, State or foreign country)		(Duration) _____ yrs. _____ mos. _____ ds.	
<i>dry Creek, Ia, Marion Co.</i>			
PARENTS	NAME OF FATHER	Contributory (SECONDARY) _____	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	(Duration) _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER	(Signed) <i>W. A. von Gump</i> M. D.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<i>Oct. 8</i> , 191 <i>2</i> (Address) <i>Alison, Mo.</i>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Wm Copeland</i>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
(ADDRESS) <i>Hayden, Mo.</i>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
Filed <i>Oct 10 1912</i> <i>Peter Terry</i> REGISTRAR		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	DATE OF BURIAL
		<i>Kenner Graveyard</i>	<i>Oct 9</i> , 191 <i>2</i>
		UNDERTAKER	ADDRESS
		<i>None</i>	

Original file, date *Oct 10 1912*, All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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