

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 Saline
Township Miami
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 797 File No. 34931
Primary Registration District No. 6040 Registered No. _____

FULL NAME Rufus Stephens (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 <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE, MARRIED, WIDOWED OR DIVORCED <u>single</u> (Write the word)	DATE OF DEATH <u>Oct. 8, 1912</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Oct. 18, 1906</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Oct. 5, 1912, to Oct. 8, 1912,</u> that I last saw him alive on <u>Oct. 7, 1912,</u> and that death occurred, on the date stated above, at <u>8:30 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Abscess of Brain</u>	
AGE <u>5</u> yrs. <u>10</u> mos. <u>8</u> ds. if LESS than 1 day, ___ hrs. or ___ min.?			249 Duration) <u>X</u> yrs. <u>X</u> mos. <u>24</u> ds. Contributory <u>X</u> (Duration) <u>X</u> yrs. <u>X</u> mos. <u>X</u> ds. (Signed) <u>M. D. Sullivan</u> M. D. <u>Oct. 8, 1912</u> (Address) <u>Miami, Mo.</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>X</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
BIRTHPLACE (City or town, State or foreign country) <u>Saline Co. Mo.</u>			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 _____	
PARENTS	NAME OF FATHER <u>Edw. L. Stephens</u>		Contribution (Duration) <u>X</u> yrs. <u>X</u> mos. <u>X</u> ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Saline Co. Mo.</u>		(Signed) <u>M. D. Sullivan</u> M. D. <u>Oct. 8, 1912</u> (Address) <u>Miami, Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Mary Irwin</u>		*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) <u>Saline Co. Mo.</u>		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) <u>Joe Young</u>			PLACE OF BURIAL OR REMOVAL <u>Shiloh Church</u>	
(ADDRESS) <u>Miami, Mo.</u>			DATE OF BURIAL <u>Oct 9th 1912</u>	
Filed <u>Oct-8 1912</u> <u>Frank H. Sullivan</u> REGISTRAR			UNDERTAKER <u>C. F. Manning</u> ADDRESS <u>Miami Mo</u>	

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, peritonaeum*, 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 *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 SUPPLEMENTARY 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

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 Saline
Township Miami
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 799 File No. 34931
Primary Registration District No. 6040 Registered No. _____

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

FULL NAME Rufus Stephens

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE single MARRIED WIDOWED OR DIVORCED
(Write the word)
DATE OF BIRTH Oct. 18, 1906
(Month) (Day) (Year)
AGE 5 yrs. 11 mos. 8 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) Saline Co. Mo.
PARENTS
NAME OF FATHER Carl C. Stephens
BIRTHPLACE OF FATHER (City or town, State or foreign country) Saline Co. Mo.
MAIDEN NAME OF MOTHER Mary Irwin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Saline Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Young
(ADDRESS) Miami, Mo.

Filed 6-6-12 Beulah H. Sullivan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 8, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct. 7, 1912 to Oct. 8, 1912, that I last saw him alive on Oct. 7, 1912 and that death occurred, on the date stated above, at 8:30 a. m.

THE CAUSE OF DEATH* was as follows:
Abcess of brain probably Tubercular, Temporo-Sphenoidal Lobe
(Duration) _____ yrs. _____ mos. 24 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) B. H. Sullivan M. D.
Oct. 8, 1912 (Address) Miami, 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 Shiloh Church DATE OF BURIAL Oct. 9, 1912
UNDERTAKER J. F. Cunningham ADDRESS Miami, Mo.

Revised United States Standard Certificate of Death

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

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of 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*.

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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*" ("*Con-genital*," "*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.)