

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 Wayne
Township Witchell
or
Village Witchell
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 903 File No. 35181
Primary Registration District No. 6712 Registered No. 18

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

FULL NAME Thomas E. Estelle

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(Write the word)

DATE OF BIRTH May 27, 1834
(Month) (Day) (Year)

AGE 78 yrs. 4 mos. 9 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Was ship block maker
(b) General nature of industry, business, or establishment in which employed (or employer) Worked in Govt navy yard

BIRTHPLACE (City or town, State or foreign country) N.Y.

NAME OF FATHER not known

BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont know

MAIDEN NAME OF MOTHER Dont know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Kater
(ADDRESS) Grant City Mo

Filed Oct 3, 1912 John Andrews
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 3, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 21, 1912, to Oct 2, 1912, that I last saw him alive on Oct 2nd, 1912, and that death occurred, on the date stated above, at 3:15 AM.

The CAUSE OF DEATH* was as follows:
Paralysis - Senility & Chr Bronchial Asthma
87 1/2
87 1/2 (Duration) 15 mos. 15 ds.

Contributory Senility & Chr Bronchial Asthma (Duration) 15 yrs. 15 mos. 15 ds.

(Signed) O. P. M. Wells M. D.
Oct 3 - 1912 (Address) Grant City, 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 15 yrs. 15 mos. 15 ds. In the State 15 yrs. 15 mos. 15 ds.

Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Regold city Iowa DATE OF BURIAL Oct 4, 1912

UNDERTAKER Scudder & Atkins ADDRESS Grant city

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 *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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Woodh Registration District No. 903 File No. 35181 ✓
Township Fletcher or Village _____ Primary Registration District No. 6212 Registered No. 18
City _____ (NO. _____ St. _____ Ward _____)

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

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

FULL NAME Thomas C. Estell

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) s.

DATE OF BIRTH May 27, 1834
(Month) (Day) (Year)

AGE 78 yrs. 4 mos. 9 ds. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work was ship block maker
(b) General nature of industry, business, or establishment in which employed (or employer) worked in East New York

BIRTHPLACE (City or town, State or foreign country) N. J.

PARENTS
NAME OF FATHER Not known
BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know
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) L. F. Kater

(ADDRESS) Grant City Mo.

Filed Oct. 3, 1912 J. H. Anderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 3, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 21, 1912, to Oct. 2, 1912, that I last saw him alive on _____, 1912, and that death occurred, on the date stated above, at 3:15 a.

The CAUSE OF DEATH* was as follows:
0 Hemiplegia, due to a. apoplexy or thrombosis.

(Duration) _____ yrs. _____ mos. 15 ds.

Contributory Senility, Chr. Bronchial asthma (SECONDARY) (Duration) several yrs. ds.

(Signed) A. P. M. Miller M. D.
Oct. 3, 1912 (Address) Grant City 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 Ringold City Iowa DATE OF BURIAL Oct. 4, 1912

UNDERTAKER Sanders Adkins ADDRESS Grant City

SUPPLEMENTARY

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 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.)