

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dec 16/17

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

PLACE OF DEATH

County Alcherson

Township \_\_\_\_\_

Registration District No. 19

File No. 38236-13

Village \_\_\_\_\_

Primary Registration District No. 4013

Registered No. 25

City Rockport

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Wesley Allyn Rich

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) infant

Female white

DATE OF DEATH

12 16, 1912  
(Month) (Day) (Year)

DATE OF BIRTH

9 24, 1916  
(Month) (Day) (Year)

AGE

2 22 ds. If LESS than 1 day, hrs. or min.?

I HEREBY CERTIFY, that I attended deceased from Nov. 10, 1912, to December 16, 1912, that I last saw her alive on December 16, 1912, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:  
Congenital debility  
119B conditions  
158  
10 1/2 yrs. 10 mos. 15 ds.

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) Rock Port mo.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

NAME OF FATHER

Orus Rich

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Pushana Bohra

MAIDEN NAME OF MOTHER

Virginia Toliver

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Rock Port mo.

(Signed) OMC C Hambolain M. D.  
Dec 17, 1912 (Address) Rock Port 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) D A Rich  
(ADDRESS) Rock Port mo.

PLACE OF BURIAL OR REMOVAL

Green Hill cemetery

DATE OF BURIAL

12/17, 1912

UNDERTAKER

E. H. King

ADDRESS

Rock Port mo.

Filed 12/17, 1912. Orlando H. Giffert REGISTRAR

# 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*, *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 "Asthma," "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.)

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 Aitchison  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Rockport (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 19 File No. \_\_\_\_\_  
Primary Registration District No. 4013 Registered No. 25

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

FULL NAME Wesley Allyn Rich.

PERSONAL AND STATISTICAL PARTICULARS

|   |                        |  |
|---|------------------------|--|
| SEX <u>F</u>  | COLOR OR RACE <u>W</u> | SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Infant</u> |
| DATE OF BIRTH <u>9 24 1912</u><br>(Month) (Day) (Year)  |                        |  |
| AGE <u>2</u> yrs. <u>22</u> mos. <u>22</u> ds.  |                        | IF LESS than 1 day, ___ hrs. or ___ min.?                            |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |                        |  |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 12 16 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 16, 1912, to Dec. 16, 1912, that I last saw her alive on \_\_\_\_\_, 1912, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:  
congenital Debility. X  
Transition  
marasmus  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) M. C. Chasler M. D. 12/17 1912 (Address) Rockport 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 \_\_\_\_\_

BIRTHPLACE (City or town; State or foreign country) Rocky Port Mo.

NAME OF FATHER Oren Rich

BIRTHPLACE OF FATHER (City or town, State or foreign country) Wishana Botma

MAIDEN NAME OF MOTHER Virginia Toliver

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rock Port Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
Informant V. A. Rich  
(ADDRESS) Rocky Port Mo.

PLACE OF BURIAL OR REMOVAL Green Hill Cem. DATE OF BURIAL 12/17 1912  
UNDERTAKER E. V. Muntz ADDRESS Rock Port Mo.

Filed 12/17 1912 V. M. Redgwick REGISTRAR

PERMANENT RECORD

N. B. - Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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 "*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.)

38236-B

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

PLACE OF DEATH

County Atchison  
Township \_\_\_\_\_  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

FULL NAME Wesley Allen T. Gick

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_  
SINGLE MARRIED WIDOWED OR DIVORCED  
(Write the word)

DATE OF DEATH \_\_\_\_\_ 1919  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, when I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred; on the date stated above, at \_\_\_\_\_ m.

AGE \_\_\_\_\_  
If LESS than 1 day \_\_\_\_\_ hrs \_\_\_\_\_ min  
\_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

The CAUSE OF DEATH\* was as follows:  
Debilty - Inanition  
Gastro-enteritis

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) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

NAME OF FATHER \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

BIRTHPLACE OF FATHER: (City or town, State or foreign country) \_\_\_\_\_

(Signed) \_\_\_\_\_ M. D.  
\_\_\_\_\_ 191\_\_\_\_ (Address) \_\_\_\_\_

MAIDEN NAME OF MOTHER \_\_\_\_\_

BIRTHPLACE OF MOTHER: (City or town, State or foreign country) \_\_\_\_\_

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

At place of death \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

(ADDRESS) \_\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_

REGISTRAR

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. J. M. G. Adenbush, Registrar, Atchison, Mo.

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
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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.)

5-25285