

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 Madison
Township Sioux
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 27 File No. D38251
Primary Registration District No. S030 Registered No. 17

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

FULL NAME Thomas Wilkerson Jr

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH Dec 19, 1912
(Month) (Day) (Year)

AGE _____ yrs. _____ 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) _____

BIRTHPLACE (City or town, State or foreign country) Ladsonia

NAME OF FATHER Riley Wilkerson

BIRTHPLACE OF FATHER (City or town, State or foreign country) no

MAIDEN NAME OF MOTHER Essie Everts

BIRTHPLACE OF MOTHER (City or town, State or foreign country) no

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Riley Wilkerson

(ADDRESS) Ladsonia Mo

Filed Dec 20 1912 W. E. Corbett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 20, 1912
(Month) (Day) (Year)

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: Heart
Knock Child kind
24 hrs,
158

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

Contributory Heart Knock
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.
_____, 191____ (Address)

*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. 1 ds. In the State _____ yrs. _____ mos. 1 ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Littley Church DATE OF BURIAL Dec 21, 1912

UNDERTAKER W. E. Corbett ADDRESS Ladsonia Mo,

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 _____ Registration District No. _____ File No. _____
 Township _____ Primary Registration District No. _____ Registered No. _____
 or _____
 Village _____ City _____ (NO. _____) St. _____ Ward _____
 City _____ (NO. _____) _____
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____, 19____ (Day) _____, 19____ (Year) _____
 IF LESS than 1 day, _____ hrs. _____ min. or _____ mos. _____ ds.

AGE _____ yrs. _____ mos. _____ ds.

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 _____ (Month) _____, 19____ (Day) _____, 19____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

BIRTHPLACE _____ (City or town, State or foreign country)

NAME OF FATHER _____

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

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) _____

(ADDRESS) _____

Filed _____, 19____, _____ REGISTRAR

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

Contributory _____ (SECONDARY)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. M. D. _____, 19____ (Address) _____

*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 _____, 19____

UNDERTAKER _____

ADDRESS _____

WRITE MAINLY, 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.

PLACE OF DEATH

County Audrain
 Township Linn
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

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

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

Registration District No. 27 File No. 38251
 Primary Registration District No. 5035 Registered No. _____

FULL NAME Thomas Wilkerson Jr.

(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 OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Dec. 19, 1912</u> (Month) (Day) (Year)		IF LESS than 1 day, ____ hrs. or ____ min.?
AGE ____ yrs. ____ mos. <u>1</u> ds.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Ladsonia Mo.</u>		
PARENTS	NAME OF FATHER <u>Riley Wilkerson</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Evelyn Everts</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Dec. 20, 1912
(Month) (Day) (Year)

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: Blout know, child lived 24 hrs.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Blout know
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. Elwood M. D.
Dec 21, 1912 (Address) Rock Hill 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) Riley Wilkerson
 (ADDRESS) Ladsonia Mo.

Filed Dec 23, 1912 (191____)
 REGISTRAR A. Elwood

PLACE OF BURIAL OR REMOVAL
Littleby Church

DATE OF BURIAL
Dec. 21, 1912

UNDERTAKER
J. W. Aydell

ADDRESS
Ladsonia 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, 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 "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.)