

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

PLACE OF DEATH

County Clay

Township \_\_\_\_\_

or

Village \_\_\_\_\_

or

City Excelsior Springs (NO. \_\_\_\_\_)

Registration District No. 198

File No. 38692

Primary Registration District No. 3011

Registered No. 131

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

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

FULL NAME William Pack

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan Dec 7<sup>th</sup> 1885  
(Month) (Day) (Year)

AGE 26 yrs. 11 mos. 25 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Teacher  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Platt Mo.

NAME OF FATHER R. W. Pack

BIRTHPLACE OF FATHER (City or town, State or foreign country) Platt Mo.

MAIDEN NAME OF MOTHER Sarah A. Price

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. W. Pack

(ADDRESS) Excelsior Springs Mo.

Filed Dec. 3 1912 T. M. Bogart REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 2 - 1 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 2, 1912, to Dec 2, 1912, that I last saw him alive on Dec 2, 1912, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:  
Shot from gun  
11:45  
Accident (Home)

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

(Signed) W. C. Hessel M. D.  
12/3, 1912 (Address) Excelsior Springs 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 8 yrs. 3 mos. \_\_\_ ds. In the State 26 yrs. 11 mos. 25 ds.

Where was disease contracted If not at place of death?  
Former or usual residence Platteburg Mo.

PLACE OF BURIAL OR REMOVAL Excelsior Springs DATE OF BURIAL Dec 3<sup>rd</sup> 1912

UNDERTAKER Excelsior Springs ADDRESS Excelsior Springs Mo.

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.

# 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.)

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

PLACE OF DEATH

County Clay  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City Excelsior Springs

MISSOURI STATE BOARD OF HEALTH  
 REGISTRARS SHALL NOT RE-BUREAU OF VITAL STATISTICS  
 CEIVE A FEE FOR CERTIFICATES  
 UNTIL THEY ARE COMPLETED AS  
 PRESCRIBED BY LAW.  
 CERTIFICATE OF DEATH

Registration District No. 198 File No. \_\_\_\_\_  
 Primary Registration District No. 3011 Registered No. 131  
 St.: \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME William Pack

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
DATE OF BIRTH <u>Dec. 7</u> , 1885 (Month) (Day) (Year)		
AGE <u>26</u> yrs. <u>11</u> mos. <u>25</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Teamster</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Platte Co.</u>		
PARENTS	NAME OF FATHER <u>R. W. Pack</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Platte Co.</u>	
	MAIDEN NAME OF MOTHER <u>Sarah A. Price</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Platte Co.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 2, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 2, 1912, to Dec. 2, 1912, that I last saw him alive on Dec. 2, 1912, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH\* was as follows:  
Chloroform poisoning  
suicidal

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

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

(Signed) O. O. Lee M. D.  
12/3, 1912 (Address) Excelsior Spgs.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) R. W. Pack  
 (ADDRESS) Excelsior Spgs.  
 Filed Feb. 7 1912 T. W. Bogard REGISTRAR

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 <u>Excelsior Spgs.</u>	DATE OF BURIAL <u>Dec. 3</u> , 191 <u>2</u>
UNDERTAKER <u>Exc. Spgs. Und. Co., Exc. Spgs. Mo.</u>	ADDRESS

Original file, date DEC 3 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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*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 "Asthena," "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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