

## PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHCounty Sumner  
Township Suber  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)Registration District No. 292  
Primary Registration District No. 5458File No. 38900  
Registered No. 113FULL NAME Wm. C. Austin

[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 male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single  
(Write the word)DATE OF DEATH Dec 23<sup>rd</sup>, 1912  
(Month) (Day) (Year)DATE OF BIRTH April 2, 1888  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec 20, 1912, to Dec 23<sup>rd</sup>, 1912, that I last saw him alive on Dec 23<sup>rd</sup>, 1912,AGE 24 yrs. 8 mos. 21 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?and that death occurred, on the date stated above, at 10 P.M.  
The CAUSE OF DEATH\* was as follows:OCCUPATION (a) Trade, profession, or particular kind of work Farming  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_Spinal Meningitis  
11B  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.BIRTHPLACE Sumner CO Mo  
(City or town, State or foreign country)Contributory X  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.PARENTS NAME OF FATHER J. B. Austin  
BIRTHPLACE OF FATHER Anderson CO Mo  
(City or town, State or foreign country)(Signed) M. C. Burke M. D.  
Dec. 23, 1912 (Address) Sumner MoMAIDEN NAME OF MOTHER Jancy Boss  
BIRTHPLACE OF MOTHER Anderson CO Mo  
(City or town, State or foreign country)

\*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

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

(Informant) J. B. Austin  
(ADDRESS) Sumner Mo

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

Filed 12/24, 1912 W E Handley  
REGISTRAR

Where was disease contracted if not at place of death?

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Sumner Cemetery DATE OF BURIAL 12/24, 1912UNDERTAKER L P McDaniel ADDRESS Sumner 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.

**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, 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 "Asthemia," "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 RE-BUREAU OF VITAL STATISTICS  
 CEIVE A FEE FOR CERTIFICATES  
 UNTIL THEY ARE COMPLETED AS  
 PRESCRIBED BY LAW.

CERTIFICATE OF DEATH

PLACE OF DEATH

County Dunklin  
 Precinct Salern

Registration District No. 290 File No. \_\_\_\_\_

Primary Registration District No. 5408 Registered No. 123

FULL NAME

Wm. E. Austin

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

PERSONAL AND STATISTICAL PARTICULARS

COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S.  
 (If give the word)

DATE OF BIRTH April 2, 1887  
 (Month) (Day) (Year)

AGE 24 yrs. 8 mos. 21 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farming  
 (b) Official nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, or foreign country) Dunklin Co. Mo.

NAME OF FATHER J. B. Austin

BIRTHPLACE OF FATHER (City or town, State or foreign country) Henderson Co. Tenn.

MAIDEN NAME OF MOTHER Nancy Boss

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Henderson Co. Tenn.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 23, 1912  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec. 20, 1912, to Dec. 23, 1912, that I last saw him alive on Dec. 23, 1912, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH\* was as follows:  
Symptomatic meningitis probably of European origin not Epidemic  
 (Duration) yrs. \_\_\_ mos. 4 ds.

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

(Signed) M. C. Burks M. D. (Address) Senath Mo.  
Dec. 23, 1912

\*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 Senath Cemetery DATE OF BURIAL 12/24, 1912

UNDERTAKER C. O. McDaniel ADDRESS Senath Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. B. Austin

(ADDRESS) Senath Mo.

Filed 12/24 1912 REGISTRAR [Signature]

# 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 *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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