

MARGIN RESERVED FOR BINDING

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.

PLACE OF DEATH

County Greene

Township _____

or

Village _____

or

City Springfield (NO. Springfield Hospital Ward)

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

Registration District No. 318

File No. 39000

Primary Registration District No. 2001

Registered No. 695

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

FULL NAME Tika Noda (Japanese)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
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DATE OF BIRTH _____

(Month) _____ (Day) _____ (Year) _____

AGE about

36 yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) Japan

PARENTS

NAME OF FATHER Don't know

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Japan

MAIDEN NAME OF MOTHER Don't know

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Japan

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Schumyer

(ADDRESS) Springfield Mo

Filed Dec 12, 1912

Wilbur Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Sept 12, 1912
(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from Sept 10, 1912, to Sept 12, 1912, that I last saw him alive on Sept 12, 1912, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Dysphasia

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

Contributory

(SECONDARY)

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

(Signed) W.S. Hopkins

M. D.

Dec 12, 1912

(Address) Springfield 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

Hazelwood

DATE OF BURIAL

Dec 12, 1912

UNDERWRITER

W. Schumyer

ADDRESS

305 N. Walnut

United States Standard Certificate of Death

[U. S. Census and American Public Health
Association]

Occupation.—Precise statement of occupation is important, so that the relative health-pursuits can be known. The question and every person, irrespective of occupations a single word or term on the certificate should be sufficient, e. g., *Farmer* or *Planter*, *Miner*, *Architect*, *Locomotive engineer*, *Stationary fireman*, etc. But in many of the industrial employments, it is necessary to state (a) the kind of work and also (b) the business or industry, and therefore an example is provided for the latter statement; it is to be given only when needed. As examples: (a) *Mill worker on mill*; (a) *Salesman*, (b) *Grocery*; (a) *Automobile factory*. The material part of the second statement is "Laborer," "Foreman," "Manager," etc. Without more precise specification, as *Coal miner laborer*, *Laborer—Coal mine*, etc. For persons who are engaged in the duties of the household, not paid *Housekeepers* who receive a salary may be entered as *Housewife*, *Housemaid*, and children, not gainfully employed, *At home*. Care should be taken to register the occupations of persons engaged in the household for wages, as *Servant*, *Cook*, *Housemaid*. If an occupation has been changed or given up, the cause of the DISEASE CAUSING DEATH, state the nature of illness. If retired from business, it may be indicated thus: *Farmer (retired)*. For persons who have no occupation enter *None*.

Cause of death.—Name, first, the cause of DEATH (the primary affection with remote causation), using always the same name for the same disease. Examples: *Cerebro-meningitis* (the only definite synonym is "Epidemic cerebro-meningitis"); *Diphtheria* (avoid use of *Strangulated tonsillitis*); *Typhoid fever* (never report "Typhoid Lobar pneumonia"; *Bronchopneumonia* unqualified, is indefinite); *Tuberculosis of lungs*, *peritoneum*, 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.)

Missouri

