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.

 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 septichaemia," "Puerperal peritonitis," etc. State cause for which surgical operation For VIOLENT DEATHS state MEANS OF was undertaken. INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMI-CIDAL, 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 STATE BOARD OF HEALTH ACE OF DEATH REGISTRARS SHALL NOT RE. BUREAU OF VITAL STATISTICS CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CERTIFICATE OF DEATH Township Registration District No or Village If death occurred in a hospital or institution. give its NAME instead of street and number] PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH SINGLE 8EX COLOR OR RACE DATE OF DEATH MARRIED W OR DIVORCED (Write the word) (Month) (Day) DATE OF BIRTH CERTIFY. that I attended deceased from (Month) (Day) (Year) AGE If LESS than day,___hrs and that death occurred, on the date stated above, at 3 or___min.? The CAUSE,OF DEATH* was as follows: 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) Contributory NAME OF (SECONDARY) FATHER (Duration) BIRTHPLACE OF FATHER (City or town, State or foreign county) MAIDEN NAME *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Heans of Injury: and (2) whether Accidental, Suicidal, or Homicidal. OF MOTHER LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR BIRTHPLACE RECENT RESIDENTS) OF MOTHER In the (City or town. State or foreign county At place ds. State ___mos._ Where was disease contracted if not at place of death? Former or usual residence ACE OF BURIAL OR REMOVAL DATE OF BURIAL REGISTRAR All information called for must be written on this Supplementary Certificate. Original file, date.

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