

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 Linn

Township _____

or Village _____

or City Nevada Mo.

(NO. _____ St.; _____ Ward)

Registration District No. 875

File No. 41814

Primary Registration District No. 3039

Registered No. 222

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

FULL NAME Arthur Manuel

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(If write the word)

DATE OF BIRTH November 18 1880
(Month) (Day) (Year)

AGE 32 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Employee
(b) General nature of industry, business, or establishment in which employed (or employee) Packing House

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

PARENTS
NAME OF FATHER Geo. Manuel
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER not obtainable
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. E. Harvey

(ADDRESS) Nevada Mo.

Filed Dec 2 1912 G. L. Wilson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 1, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 20, 1912, to Dec 1, 1912, that I last saw him alive on Dec 1, 1912, and that death occurred, on the date stated above, at 4 P.-m.

The CAUSE OF DEATH* was as follows:
Meningitis
79 B W
(Duration) _____ yrs. _____ mos. 6 ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) [Signature] M. D.
(Address) Nevada, 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 Nevada Mo.

PLACE OF BURIAL OR REMOVAL Leopwood DATE OF BURIAL 12/3, 1912

UNDERTAKER [Signature] ADDRESS Nevada Mo

[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*, *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 "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.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH
County Vernon
Township _____
or _____
Village _____
or _____
City Nevada (NO. _____ St.; _____ Ward)

Registration District No. 875 File No. _____
Primary Registration District No. 3039 Registered No. 222

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

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(If wife the word)
DATE OF BIRTH unknown, 1880
(Month) (Day) (Year)
AGE 32 yrs. mos. ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Employee
(b) General nature of industry, business, or establishment in which employed (or employer) Packing House

BIRTHPLACE (City or town, State or foreign country) Mo.
PARENTS
NAME OF FATHER Geo. Manuel
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
MAIDEN NAME OF MOTHER Not obtainable
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Havelly
(ADDRESS) Nevada, Mo.

Filed Feb 13 1912 W. J. Waincott REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec. 1, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Nov 25, 1912, to Dec. 1, 1912, that I last saw him alive on Dec. 1, 1912, and that death occurred, on the date stated above, at 4p. m.
The CAUSE OF DEATH* was as follows:

meningitis
Cerebro spinal meningitis

(Duration) ___ yrs. ___ mos. ___ ds. 6
Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds. _____
(Signed) [Signature] M. D.
(Address) Nevada, 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 Deepwood DATE OF BURIAL 12-3 1912
UNDERTAKER W. J. Waincott ADDRESS Nevada

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Revised United States Standard Certificate of Death

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

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