

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 <u>Greene</u>	MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
County <u>Greene</u>	Registration District No. <u>318</u>	File No. <u>993</u>
Township _____ or Village _____	Primary Registration District No. <u>2001</u>	Registered No. <u>32</u>
City <u>Springfield</u> (NO. <u>W. Olive</u> St. <u>2</u> Ward)	(If death occurred in a hospital or institution, give its NAME instead of street and number)	
FULL NAME <u>Evan Duman</u>		

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Single</u>	DATE OF DEATH <u>Jan. 17</u> 191 <u>3</u> (Month) (Day) (Year)
DATE OF BIRTH <u>May 4</u> 191 <u>1</u> (Month) (Day) (Year)		I HEREBY CERTIFY, that I attended deceased from <u>Jan 17th</u> , 191 <u>3</u> , to <u>Jan. 17th</u> , 191 <u>3</u> , that I last saw him alive on <u>Jan. 17th</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>7:30</u> m.	
AGE <u>1</u> yrs. <u>8</u> mos. <u></u> ds.	IF LESS than 1 day, _____ hrs. or _____ min.?	The CAUSE OF DEATH* was as follows: <u>Spasms super caused by Paratyphoid</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>at Home.</u>		Contributory (SECONDARY) <u>Spasms</u>	
(b) General nature of industry, business, or establishment in which employed (or employer)		(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		(Signed) <u>W. G. Parrelly</u> M. D. <u>Jan 18th</u> 191 <u>3</u> (Address) <u>Springfield Mo.</u>	
PARENTS	NAME OF FATHER <u>Homer Duman</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Ella Grider</u>	At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	Where was disease contracted If not at place of death? Former or usual residence.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>B. E. Criss</u>		PLACE OF BURIAL OR REMOVAL <u>Wasson Cem.</u>	DATE OF BURIAL <u>Jan 18</u> 191 <u>3</u>
(ADDRESS) <u>317 R. Campbell</u>		UNDERTAKER <u>J. H. Smith</u>	ADDRESS <u>W. Olive St. Springfield</u>
Filed <u>Jan 18, 1913</u> <u>W. H. Smith</u> REGISTRAR			

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 lung*, *meninges*, *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.)



ould state
important.

PLACE OF DEATH

County Greene

Township _____
or _____

Village _____
or _____

City Springfield (NO. W. Clew)

FULL NAME Evan Inman

REGISTRARS SHALL NOT RE-CEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

318

Registration District No. _____

File No. _____

Primary Registration District No. 2001

Registered No. 32

[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
(Write the word)

DATE OF BIRTH May 4, 1911
(Month) (Day) (Year)

AGE 1 yrs. 8 mos. ds. if LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

PARENTS NAME OF FATHER Homer Inman BIRTHPLACE OF FATHER Mo.
MAIDEN NAME OF MOTHER Ellen Grider BIRTHPLACE OF MOTHER Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) B. E. Crain

(ADDRESS) 317 S. Campbell

Filed Feb 3 1913 Walker Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan. 17, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 17, 1913, to Jan. 17, 1913, that I last saw him alive on Jan. 17, 1913, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Spasms
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. L. Purcell M. D. Jan. 18, 1913 (Address) Springfield

*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 Patterson Cem. DATE OF BURIAL Jan. 18, 1913

UNDERTAKER Paxson Und. Co. ADDRESS 410 South

Original file, date JAN 1913 All information called for must be written on this Supplementary Certificate.

WRITE PLAIN

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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