

MARGIN RESERVE 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. _____ St.: _____ Ward)

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

Registration District No. 318 File No. 5022
 Primary Registration District No. 2001 Registered No. 122

FULL NAME George Oliver Crosby

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb 12, 1913
 (Month) (Day) (Year)

AGE _____ yrs. _____ mos. 13 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
 NAME OF FATHER W. S. Crosby
 BIRTHPLACE OF FATHER (City or town, State or foreign country) W. Carolina
 MAIDEN NAME OF MOTHER Carlora E. Parker
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) X

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. S. Crosby
 (ADDRESS) Sumner 2033

Filed Feb 26, 1913 Wilbur Smith
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH February 25th, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 24th, 1913, to Feb. 25th, 1913, that I last saw him alive on Feb. 24th, 1913, and that death occurred, on the date stated above, at 9 a.m.
 The CAUSE OF DEATH* was as follows:

Bronch pneumonia
 (Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Albert J. Hallier M. D. Feb. 25 1913 (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 Washwood DATE OF BURIAL 2/26 1913

UNDERTAKER D. Marshall ADDRESS 603 1/2 E. Main

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*, *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*, *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 "Asthena," "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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PLACE OF DEATH
 County Greene
 Township _____
 or _____
 Village _____
 or _____
 City Springfield (NO. _____) St. _____ Ward _____

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

Registration District No. 318 File No. _____
 Primary Registration District No. 2001 Registered No. 122

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

FULL NAME George Oliver Crosby

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE Wgto SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

DATE OF BIRTH Feb 12, 1913
 (Month) (Day) (Year)

AGE 13 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

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) Springfield

PARENTS NAME OF FATHER W. S. Crosby BIRTHPLACE OF FATHER (City or town, State or foreign country) N. Co. MAIDEN NAME OF MOTHER Edna Marie Parker BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. S. Crosby

(ADDRESS) 2033 Vernon Ave

Filed April 17, 1913 C. W. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 25, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 24, 1913, to Feb 25, 1913, that I last saw him alive on Feb 24, 1913, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
 (Duration) _____ yrs. _____ mos. 4 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) Albert F. Miller M. D. Feb 25, 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 Hayward DATE OF BURIAL 2/26, 1913 UNDERTAKEER D Marshall ADDRESS 603 N Jefferson

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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