

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 Callaway  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Fulton

Registration District No. 104 File No. 15858  
Primary Registration District No. 3008 Registered No. 78  
St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME John Lambert

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Negro SINGLE Married  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH Don't know 1869  
(Month) (Day) (Year)

AGE 44 yrs. Don't know mos. None If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work Laborer & Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer) Self

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

PARENTS  
NAME OF FATHER Don't know  
BIRTHPLACE OF FATHER (City or town, State or foreign country) don't know  
MAIDEN NAME OF MOTHER Mary Ramsey  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Callaway

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Bertha Lambert

(ADDRESS) 221 East B Street

Filed May 20 1913 W E Peely  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 19, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1913, to May 19, 1913  
that I last saw him alive on May 18, 1913,  
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH\* was as follows:

Septicemia  
Wound on Hand  
194 B (Duration) yrs. \_\_\_\_ mos. 19 ds.

Contributory (SECONDARY) (Duration) yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) J. D. Lupton M. D.  
May 20 1913 (Address) Fulton 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 \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Fulton Mo DATE OF BURIAL May 20 1913

UNDERTAKER W E Peely ADDRESS Fulton

# 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 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 "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.)



## PLACE OF DEATH

County

leallaway

Township

or

Village

or

City

Fulton

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

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Registration District No.

104

File No.

Primary Registration District No.

3008

Registered No.

79

(NO.

St.

Ward)

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

FULL NAME

John Lam test

## PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

Negro

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Married

DATE OF BIRTH

Don't know, 1869

(Month)

(Day)

(Year)

AGE

44 yrs. Don't know

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)

NAME OF

FATHER

BIRTHPLACE

OF FATHER

(City or town, State or foreign country)

MAIDEN NAME

OF MOTHER

BIRTHPLACE

OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

5/20

1913

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May

19

1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

191, to 191,

that I last saw him on 191,

and that death occurred, on the day stated above, at m.

The CAUSE OF DEATH\* was as follows:

Septicemia

wound on hand  
(Accident)

(Duration) yrs. mos. 19 ds.

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

J. H. Sexton

M. D.

May 20, 1913

(Address) Fulton, 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

DATE OF BURIAL

UNDERTAKER:

ADDRESS

Original file, date MAY 1913 19

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY  
Satisfactory Information Supplied

Satisfactory Information Supplied

Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

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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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