

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.

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

PLACE OF DEATH

County Greene

Township _____

or Village _____

or City Springfield (NO. 1541, Shannon) St. 5 Ward _____

FULL NAME Wm Shaw

Registration District No. 318

File No. 19511

Primary Registration District No. 2001

Registered No. 352

[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 Married
WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH April 19, 1839
(Month) (Day) (Year)

AGE 74 yrs. 2 mos. 9 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Rail Road Conductor.
(b) General nature of industry, business, or establishment in which employed (or employer) 4-103

BIRTHPLACE (City or town, State or foreign country) Lafayette Ind.

NAME OF FATHER Samuel Shaw.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio.

MAIDEN NAME OF MOTHER Sara Gose

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rudolph Grove Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE wife
(Informant) Mrs Amanda Shaw

(ADDRESS) Springfield Mo

Filed June 29, 1913 D. C. W. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from March 10, 1913, to June 28, 1913,
that I last saw him alive on June 28, 1913,
and that death occurred, on the date stated above, at 3:20 PM

The CAUSE OF DEATH* was as follows:
Chronic nephritis
131
(Duration) 2 yrs. 1 mos. — ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Enoch Stubb M. D.
June 29, 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 Maple Park cemetery DATE OF BURIAL _____ 1913

UNDERTAKER Parson and Co 410 South St. ADDRESS _____

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, 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.)

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.

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

PLACE OF DEATH

County Greene

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

Township _____

Registration District No. 318

File No. 352

or
Village _____

Primary Registration District No. 2001

Registered No. _____

or
City Springfield (NO. 1341 Sherman St. 5 Ward)

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

FULL NAME Wm Shaw

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX _____ COLOR OR RACE _____
Satisfactory Information
SINGLE MARRIED
MARRIED Widowed
OR DIVORCED
(If wife the word)

DATE OF DEATH June 28, 1913
(Month) (Day) (Year)

DATE OF BIRTH _____
Satisfactory Information
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Satisfactory Information
that I last saw h. _____ alive on _____, 191____,
and that death occurred, on the date stated above, _____, 191____.

AGE _____
Satisfactory Information
If LESS than
day _____ hrs _____
or min _____
yrs _____ mos _____ ds _____

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) _____

(Duration) _____ yrs _____ mos _____ ds.

NAME OF FATHER _____

Contributory
(SECONDARY) _____
(Duration) _____ yrs _____ mos _____ ds.

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

(Signed) _____ M. D.

MAIDEN NAME OF MOTHER _____

(Address) _____ 191____

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR
RECENT RESIDENTS)
At place of death _____ yrs _____ mos _____ ds. In the State _____ yrs _____ mos _____ ds.

(Informant) _____

Where was disease contracted
If not at place of death? _____

(ADDRESS) _____

Former or usual residence _____

Filed June 24, 1913 W. Smith REGISTRAR

PLACE OF BURIAL OR REMOVAL Maple Park, Cem. DATE OF BURIAL June 30, 1913
UNDERTAKER Wayson and Co ADDRESS 410 South St.

Revised United States Standard Certificate of Death

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

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1951
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.)