

MARGIN RESERVED 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 New Madrid
 Township Coatage
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 607 File No. 20370
 Primary Registration District No. 5806 Registered No. _____

FULL NAME Geo H. Welch

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

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---------------|--|---|
| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
| DATE OF BIRTH | <u>May 8, 1881</u> (Month) (Day) (Year) | |
| AGE | <u>32</u> yrs. <u>25</u> mos. <u>25</u> 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)

| | |
|---------|--|
| PARENTS | 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) Geo Surkman

(ADDRESS) _____

Filed July 25 1913 J. M. Thompson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 2, 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 9, 1913, to June 2, 1913, that I last saw him alive on June 1, 1913, and that death occurred, on the date stated above, at 11308

The CAUSE OF DEATH* was as follows:

Tuberculosis
D & A

Contributory (SECONDARY)

(Signed) P. R. Phillips M. D.
 (Address) Coatageville 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

do not know

DATE OF BURIAL

June 2 1913

UNDERTAKER

Farmers Merc Co
Per G. M. Sutherland

ADDRESS

Coatageville

PLACE OF DEATH

**MISSOURI STATE BOA
BUREAU OF VITAL &
CERTIFICATE OF**

County _____ Township _____ Registration District No. _____ File No. _____
 or Village _____ Primary Registration District No. _____ Registered No. _____
 or City _____ (NO. _____) St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---------------|---|---|
| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) |
| DATE OF BIRTH | (Month) _____ (Day) _____ (Year) _____ | |
| AGE | _____ 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) | NAME OF FATHER |
| BIRTHPLACE OF FATHER (City or town, State or foreign country) | BIRTHPLACE OF MOTHER (City or town, State or foreign country) |
| MAIDEN NAME OF MOTHER | |

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (ADDRESS) _____
 Filed _____, 191____, _____
 REGISTRAR _____

MEDICAL CERTIFICATE OF DATE OF DEATH
 _____ (Month) _____

I HEREBY CERTIFY, that I a
 _____, 191____, to
 that I last saw h _____ alive on _____
 and that death occurred, on the date stat
 The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY)
 _____ (Duration) _____ yrs. _____
 (Signed) _____ (Duration) _____ yrs. _____
 _____ (Address) _____

*State the Disease Causing Death, or, in deaths
 (1) Meas of Injury and (2) whether Accidental, Suicidal
**LENGTH OF RESIDENCE (FOR HOSPITALS INST
 RECENT RESIDENTS)**
 At place of death _____ yrs. _____ mos. _____ ds. State _____
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

UNDERTAKER

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

County New Madrid Registration District No. 607 File No. _____

Township Postage or _____ Primary Registration District No. 5816 Registered No. _____

Village _____ or _____ City _____ (NO. _____) St. _____ Ward _____

FULL NAME John H. Welch (If death occurred in a hospital or institution, give its NAME instead of street and number)

| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | |
|---|---|---|---|--|
| SEX <u>male</u> | COLOR OR RACE <u>white</u> | SINGLE MARRIED WIDOWED OR DIVORCED <u>X</u> <u>yes</u> | DATE OF DEATH <u>6 - 2 - 1913</u> (Month) (Day) (Year) | |
| DATE OF BIRTH <u>May 8, 1881</u> (Month) (Day) (Year) | | | I HEREBY CERTIFY, that I attended deceased from <u>Satisfactory information supplied.</u> to _____, 191____, and that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. | |
| AGE <u>32</u> yrs. <u>25</u> mos. <u>5</u> ds. | | | The CAUSE OF DEATH* was as follows: <u>Tuberculosis. Lobar</u> | |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>X</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u> | | | (Duration) _____ yrs. _____ mos. _____ ds. | |
| BIRTHPLACE (City or town, State or foreign country) <u>X</u> | | | Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. | |
| PARENTS | NAME OF FATHER <u>X</u> | | (Signed) <u>F. S. Phillips</u> <u>X</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>X</u> | | <u>June 2, 1913</u> (Address) <u>Postageville</u> | |
| | MAIDEN NAME OF MOTHER <u>X</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 MOTHER (City or town, State or foreign country) <u>X</u> | | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>G. W. Sutherland</u> | | | Where was disease contracted if not at place of death? Former or usual residence _____ | |
| (ADDRESS) _____ | | | PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____ | |
| Filed <u>June 3, 1913</u> <u>J. M. Thompson</u> REGISTRAR | | | ADDRESS <u>Postageville</u> <u>Information Supplied</u> | |

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

20370

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, peritonaeum*, 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.)