

WHILE FLAINLY, 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 _____

Township _____

or

Village _____

or

City Paris - Mo (NO. Prince Hoop St.: 95 Ward)

Registration District No. 781

File No. 21516

Primary Registration District No. 1003

Registered No. 5826

FULL NAME Francis Halper Roach

(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 Feb. 14, 1895
(Month) (Day) (Year)

AGE 18 yrs. 4 mos. 11 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Laborer (light)
(b) General nature of industry, business, or establishment in which employed (or employer) Rail Road work

BIRTHPLACE (City or town, State or foreign country) Newburg - Mo

PARENTS
NAME OF FATHER Chas F. Roach
BIRTHPLACE OF FATHER (City or town, State or foreign country) Phelps Co. Mo
MAIDEN NAME OF MOTHER Miss Bess Gaddy
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Phelps Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas F. Roach

(ADDRESS) Newburg Mo

Filed 26 1913 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from June 12, 1913, to June 25, 1913, that I last saw him alive on June 25, 1913, and that death occurred, on the date stated above, at 1:15 PM.

The CAUSE OF DEATH* was as follows:
1. Brain Abscess.
78A

(Duration) ___ yrs. ___ mos. 13 ds.

Contributory Suppurative Otitis Media
(SECONDARY) (Duration) 10 yrs. ___ mos. ___ ds.

(Signed) O. O. Smith M. D.
6/25/1913 (Address) Prince Hospital

*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. 13 ds. In the 18 yrs. 4 mos. 11 ds.

Where was disease contracted If not at place of death? Newburg Mo

Former or usual residence Newburg Mo

PLACE OF BURIAL OR REMOVAL Newburg Mo DATE OF BURIAL June 26, 1913

UNDERTAKER Jegenheim, Em ADDRESS 2623 Cherokee

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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name organ; "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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

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

County _____

Township _____

or Village _____

or City _____

Registration District No. 791

File No. _____

Primary Registration District No. 1003

Registered No. 5826

City St. Louis (NO. Trues Hospital St. 25 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Francis Walker Coach

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Satisfactory Information Supplied.
 COLOR OF HAIR _____
 SINGLE _____
 MARRIED _____
 WIDOWED _____
 OR DIVORCED _____
 (Write the word)

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

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred; on the date stated above, _____ m.

AGE _____
 yrs. mos. ds.
 IF LESS than _____ day, _____ hrs. and _____ min.

The CAUSE OF DEATH* was as follows:
Brain abscess following suppurative Otitis Media Non-tuberculous in character.
No cultures made
 (Duration) _____ yrs. _____ mos. _____ ds.

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

Contributory Suppurative Otitis Media
 (SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.

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) _____

(Signed) J. O. O. Smith, M.D.
June 25, 1913 (Address) Trues Hospital

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
Satisfactory Information Supplied.

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 _____

(ADDRESS) _____
 Filed June 26, 1913
31 J. L. Madgros
 REGISTRAR

PLACE OF BURIAL OR REMOVAL _____
Satisfactory Information Supplied.
 DATE OF BURIAL _____, 191____
 UNDERTAKER _____
 ADDRESS _____

WRITE PLAIN INK WITH UNFADING INK—THIS IS A PERMANENT RECORD

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SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

71512

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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.)