

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 Dade
Township Sae
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 1109 File No. 22482
Primary Registration District No. 5333 Registered No. 7

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

FULL NAME Duncan

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>July 27, 1913</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.? <u>4</u>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>O-O</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Dade Co mo</u>		
PARENTS	NAME OF FATHER <u>Hiltsman Duncan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Dade Co mo</u>	
	MAIDEN NAME OF MOTHER <u>Rosalia Duncan</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Dade Co mo</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) <u>Hiltsman Duncan</u>		
(ADDRESS) <u>Seybert mo</u>		
Filed <u>July 25, 1913</u> <u>J. G. Ambree</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>July 22, 1913</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,	
that I last saw him alive on <u>July 21, 1913</u>	
and that death occurred, on the date stated above, at <u>6:30</u> p.m.	
The CAUSE OF DEATH* was as follows: <u>Before Full Term</u>	
_____ <u>159</u>	
_____ <u>151</u>	
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>A. Higgins</u> M. D. _____ 7/23, 1913 (Address) <u>Reola mo</u>	
*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 <u>Duncan Anctory</u>	DATE OF BURIAL <u>7/22, 1913</u>
UNDERTAKER <u>No Undertaker</u>	ADDRESS

PLACE OF BIRTH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____
 SINGLE _____ MARRIED _____
 WIDOWED _____ OR DIVORCED _____
 (If fits 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) _____
 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 _____ 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
 that I last saw h_____ alive on _____, 191____,
 and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. M. D. _____ 191____ (Address) _____

*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 _____ 191____

UNDERTAKER _____ ADDRESS _____ 191____

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.

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

PLACE OF DEATH

County Wade
 or
 Township Sac
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1109 File No. _____
 Primary Registration District No. 5333 Registered No. 78

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

FULL NAME

unnamed (Duncan)

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m.</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> (Write the word)
DATE OF BIRTH <u>July 21</u> (Month) <u>1913</u> (Year)		
AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>0</u> min.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Satisfactory Information Supplied</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Wade Co, Mo</u>		
PARENTS	NAME OF FATHER <u>Hillman Duncan</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Wade Co, Mo</u>	
	MAIDEN NAME OF MOTHER <u>Rosanna Duncan</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Wade Co, Mo</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
July 22, 1913
(Month) (Day) (Year)

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

The CAUSE OF DEATH* was as follows:
Before full term

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

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

(Signed) A. Higgins M. D.
(Address) Accola, 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Hillman Duncan
(ADDRESS) Debert, Mo

Filed July 25 1913 J. A. Hendrick
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Satisfactory Information Supplied

DATE OF BURIAL
July 22, 1913

UNDERTAKER
No Undertaker

PRINTED WITH UNFADING INK. THIS IS A PERMANENT RECORD

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.

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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

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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.)