

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 Washington Registration District No. 976 File No. 28828a  
Township Kingston or \_\_\_\_\_ Primary Registration District No. 6187 Registered No. \_\_\_\_\_  
Village \_\_\_\_\_ or \_\_\_\_\_ City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Earnest Sampson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE Yes  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF DEATH Aug 11, 1913  
(Month) (Day) (Year)

DATE OF BIRTH Feb 5, 1895  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 22, 1913, to Aug 11, 1913, that I last saw him alive on Aug 10, 1913, and that death occurred, on the date stated above, at 4 P.m.

AGE 18 yrs. 4 mos. 3 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Dysphoid Fever  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 24 ds.

OCCUPATION (a) Trade, profession, or particular kind of work Farm work  
(b) General nature of industry, business, or establishment in which employed (or employer) 1-0-0

BIRTHPLACE (City or town, State or foreign country) Washington Md

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Geo. H. Elders M. D.  
Aug 11, 1913 (Address) Hillsboro Rd Washington Md

NAME OF FATHER David Sampson

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

MAIDEN NAME OF MOTHER Mary Ann Dauber

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

\*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 18 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State 18 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence Near Bliss Pk Washington Md

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Fred Sampson

(ADDRESS) Bliss Pk, Md

PLACE OF BURIAL OR REMOVAL 11 DATE OF BURIAL Aug 12, 1913

Filed Aug 20, 1913 REGISTRAR

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

## PLACE OF DEATH

County.....  
 Township.....  
 or  
 Village.....  
 or  
 City.....

Registration District No. ....

File No. ....

Primary Registration District No. ....

Registered No. ....

(NO.....)

St. ....

Ward) .....

[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 (Write the word)
DATE OF BIRTH	(Month) .....	(Day) .....
AGE	(Month) .....	(Year) .....

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  
FATHERBIRTHPLACE  
OF FATHER

(City or town, State or foreign country) .....

MAIDEN NAME  
OF MOTHERBIRTHPLACE  
OF MOTHER

(City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS) .....

Filed

, 191.....

REGISTRAR

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

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.

## MEDICAL CERTIFICATE OF DEATH

## DATE OF DEATH

(Month) .....

(Day) .....

191.....

I HEREBY CERTIFY, that I attended deceased from  
 , 191....., to , 191.....

that I last saw h..... alive on .....

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

The CAUSE OF DEATH\* was as follows:

## Contributory

(SECONDARY)

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

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

(Signed) .....

(Address) .....

M. D.

\*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

WHILE IN LANEY, 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.

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

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

County Kingston Registration District No. 976 File No. ✓

Township Kingston or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Primary Registration District No. 6187 Registered No. \_\_\_\_\_

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (W rite 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) \_\_\_\_\_

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) \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 11, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 22, 1913, to Aug 11, 1913 that I last saw him alive on Aug 10, 1913 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH\* was as follows: \_\_\_\_\_

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

(Signed) \_\_\_\_\_ M. D. \_\_\_\_\_ 1913 (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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_ (ADDRESS) \_\_\_\_\_

Filed Aug 20 1913 J. P. Bowers REGISTRAR

PLACE OF BURIAL OR REMOVAL Richwood DATE OF BURIAL 18.18 1913

UNDERTAKER more ADDRESS \_\_\_\_\_

Original file, date Aug 1913 1913 All information called for must be written on this Supplementary Certificate.

Satisfactory Information Supplied

Satisfactory Information Supplied

# 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 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.)

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