

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 North
Township Green
or
Village P.O.
or
City Parnell Mo (No. _____)

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

Registration District No. 1057 File No. 28855
Primary Registration District No. 6214 Registered No. 6
St.; _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

Unmarried

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED ☐ (Write the word)
DATE OF BIRTH July 29, 1913
(Month) (Day) (Year)
AGE _____ yrs. _____ mos. 4 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) North Co Green Tp Mo

NAME OF FATHER Elmer Miller

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Northway Co Mo

MAIDEN NAME OF MOTHER Ellen Parnell

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) North Co Green Tp Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Miller
(ADDRESS) Parnell

Filed Aug 10, 1913 Wm. Cox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug - 2 - 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July - 28 - 1913, to Aug. 2 - 1913, that I last saw him alive on Aug. 1 - 1913, and that death occurred, on the date stated above, at 1.0 m.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) _____ yrs. _____ mos. 4 ds.

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

(Signed) Harmon Day M. D. Aug 3, 1913 (Address) Parnell

*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. 4 ds. In the State _____ yrs. _____ mos. 4 ds.

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

Former or usual residence usual

PLACE OF BURIAL OR REMOVAL Parnell DATE OF BURIAL Aug 8, 1913

UNDERTAKER Roy V. Parnell ADDRESS Parnell

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, Sar-*

coma, 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.)



N. B.—Every item of information should be carefully supplied. AGE showing months, is not 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 Worth
Township Greene
or
Village
or
City (NO. St. Ward)

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

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

Registration District No. 1057 File No. 6
Primary Registration District No. 6214 Registered No. 6

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

FULL NAME Unnamed (Miller)

PERSONAL AND STATISTICAL PARTICULARS

SEX F. COLOR OR RACE W. SINGLE S. MARRIED WIDOWED OR DIVORCED (Write the word)

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

AGE (yrs. mos. ds.) IF LESS than 1 day, hrs. or min. Satisfactory Information Supplied

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

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) Satisfactory Information Supplied

(ADDRESS)

Filed Aug 10 1913 J. M. Cox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 2 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied, 1913, to Satisfactory Information Supplied, 1913, that I last saw him Satisfactory Information Supplied, and that death occurred, on the date stated above, at Satisfactory Information Supplied m.

The CAUSE OF DEATH* was as follows:

meningitis tubercular
30 (Duration) yrs. mos. 4 ds.

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

(Signed) Alvan Dagg M. D. Aug 3 1913 (Address) Parrell, 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 DATE OF BURIAL

UNDERTAKER ADDRESS Satisfactory Information Supplied

Revised United States Standard Certificate of Death

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

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