

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 Adair  
Township Winnick  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 5 File No. 28891  
Primary Registration District No. 5002B Registered No. 23

FULL NAME Lewis E. Whittom [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 Caucasian SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Nov 1, 1885  
(Month) (Day) (Year)

AGE 28 yrs. 10 mos. 24 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS  
NAME OF FATHER Stephen Whittom  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa  
MAIDEN NAME OF MOTHER Lockett  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Wisconsin

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Minnie Griffith  
(ADDRESS) Novinger Mo

Filed Sept 25 1913 J. S. Cashwiler REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sep 9 24, 1913  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sep 19, 1913, to Sep 24, 1913, that I last saw him alive on Sep 22, 1913, and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage  
VIVE  
82A  
(Duration) \_\_\_ yrs. \_\_\_ mos. 15 ds.

Contributory Spinal injury  
(SECONDARY) (Duration) 15 yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) J. L. Dodson M. D.  
Sep 25, 1913. (Address) Kirksville 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? At home  
Former or usual residence Adair Co, Mo.

PLACE OF BURIAL OR REMOVAL Jewel Cemetery DATE OF BURIAL Sept. 25, 1913  
UNDERTAKER E. H. Swigert ADDRESS Kirkville Mo

WRITE PLAINLY WITH FADING INK—THIS IS A PERM

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 \_\_\_\_\_  
 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) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_, 191\_\_\_\_ (Year) \_\_\_\_\_  
 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

AGE \_\_\_\_\_ 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) \_\_\_\_\_

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) \_\_\_\_\_, 191\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Day) \_\_\_\_\_, 191\_\_\_\_ (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:

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

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

(Signed) \_\_\_\_\_, 191\_\_\_\_ (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. 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 \_\_\_\_\_

WRITE PLAINLY, GIVE FULL NAMES OF PLACES, DATES, AND TIMES. DO NOT WRITE IN RED INK.

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

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

PLACE OF DEATH  
County Adair  
Township Ninevah or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 5 File No. \_\_\_\_\_  
Primary Registration District No. 5002<sup>B</sup> Registered No. 23

FULL NAME Lewis E. Whitton.

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

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (Write the word)
DATE OF BIRTH <u>Satisfactory Information Supplied</u> (Month) _____ (Day) <u>1</u> (Year) _____		
AGE <u>Satisfactory Information Supplied</u> If LESS than 1 day, _____ hrs. _____ min. or _____ yrs. _____ mos. _____ ds.		
OCCUPATION (a) Trade, profession, particular kind of work <u>Satisfactory Information Supplied</u> (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 <u>Lockett</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Satisfactory Information Supplied</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 24, 1913  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

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, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Cerebral hemorrhage, cause of injury falling from load at work, which was attended  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds.

Contributory Spinal injury  
(SECONDARY) (Duration) 15 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signed W. T. Dobson M. D.  
Sept 25 1913 (Address) Kirkville, 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 Satisfactory Information Supplied DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER Satisfactory Information Supplied ADDRESS \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X From Wife X  
(ADDRESS) Novinger, Mo

Filed Sept. 25 3 1/2 P M 1913 of S Gashwill  
REGISTRAR

# 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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