

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. See instructions on back of certificate.

3-5380

PLACE OF DEATH

County Jefferson
 Township _____
 or _____
 City Joplin No. _____ street, _____ Ward.

STATE OF KANSAS.

STATE BOARD OF HEALTH

33194

STANDARD CERTIFICATE OF DEATH.

Registered No. 417

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

FULL NAME George Stanley

PERSONAL AND STATISTICAL PARTICULARS.

Sex M Color or Race W Single, Married, Widowed, or Divorced Married
(Write the word.)

Date of Birth Sept 8 1886
(Month) (Day) (Year)

Age 27 yrs. _____ mos. _____ ds. IF LESS than 1 day, — hrs. or — min. ?

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

Birthplace. S.D.
(State or country).

10 Name of Father. Foster Stanley

11 Birthplace of Father. S.D.
(State or country).

12 Maiden name of Mother. Margaret Fousett

13 Birthplace of Mother. Ohio
(State or country).

14 The above is true to the best of my knowledge.
 (Informant) Mrs Susie Stanley
 (Address) Galena Kans

Filed 10-6 1913 G. M. Gray
 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16 Date of Death. 10 - 4 1913
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1913 to 10 - 4 1913

that I last saw him alive on 10 - 3 1913
 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH * was as follows:

Typhoid fever
 (Duration) _____ yrs. _____ mos. _____ da.

Contributory (Secondary). _____
 (Duration) _____ yrs. _____ mos. _____ da.

(Signed) F. M. Curry M. D.
10-4 1913 (Address) Galena, Kans

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 Length of Residence (For hospitals, institutions, transients, or recent residents).

At place of death _____ yrs. _____ mos. _____ da. In the State _____ yrs. _____ mos. _____ da.

Where was disease contracted, if not at place of death? Pittsburg Mo

Former or usual residence. Pittsburg Mo

19 Place of Burial or Removal. Maker. Date of Burial. 10-5-1913

20 Undertaker. McCluck Address. Galena

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, peritoneum*, 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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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 Jasper
Township _____
or
Village _____
or
City Joplin (NO. _____ St.: _____ Ward)

Registration District No. 411 File No. _____
Primary Registration District No. 2002 Registered No. _____

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

FULL NAME George Stanley

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH Sept 8 1886
(Month) (Day) (Year)
AGE 27 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION (a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) _____
BIRTHPLACE (City or town, State or foreign country) S. D. MOBILE

PARENTS
NAME OF FATHER Foster Stanley
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
MAIDEN NAME OF MOTHER Myrtle Fousett
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Myrtle Stanley
(ADDRESS) Galena Mo

Filed 10-16 3:15 A.M. 1913
REGISTRAR P. M. Clark

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 10-4 1913
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from 10-4 1913, to 10-4 1913, that I last saw him alive on 10-3 1913 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. L. McKeown M. D.
10-4 1913 (Address) Galena

*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 Graves DATE OF BURIAL 10-14 1913
UNDERTAKER P. M. Clark ADDRESS Galena

Revised United States Standard Certificate of Death

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

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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 septicæmia," "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.)