

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 Pulaski  
Township Roubidoux Registration District No. 715 File No. 37140  
or Village \_\_\_\_\_ Primary Registration District No. 5944 Registered No. \_\_\_\_\_  
or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Tom Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX FM COLOR OR RACE W. SINGLE single  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH Sept. 28, 1914  
(Month) (Day) (Year)

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

OCCUPATION

(a) Trade, profession, or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country) Canning Shade

PARENTS

NAME OF FATHER A. C. Williams

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

MAIDEN NAME OF MOTHER E. E. Carrall

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. C. Williams

(ADDRESS) Cookville

Filed 11-5-18 1918 R. C. Ford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct. 26, 1918  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_,

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

The CAUSE OF DEATH\* was as follows:

lung out sickly all the time sick 188 no doctor

Contributory

(SECONDARY)

(Signed) \_\_\_\_\_ 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 Big Piney

DATE OF BURIAL 10-27-18

UNDERTAKER F. S. Skidmore

ADDRESS Cookville

# 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*, *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.)



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**MISSOURI STATE BOARD OF HEALTH**  
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**CERTIFICATE OF DEATH**

PLACE OF DEATH Pulaski  
County Roubidoux  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

Registration District No. 715 File No. \_\_\_\_\_  
Primary Registration District No. 3944 Registered No. \_\_\_\_\_

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>Fem.</u>	COLOR OR RACE <u>W.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>	DATE OF DEATH <u>Oct. 26</u> , 191 <u>9</u> (Month) (Day) (Year)		
DATE OF BIRTH _____ <u>Satisfactory Information Supplied.</u>			I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.		
AGE _____ yrs. _____ mos. <u>28</u> ds.		If LESS than 1 day, _____ hrs. or _____ mins.	The CAUSE OF DEATH* was, as follows: <u>Infant sickly all the time</u> <u>no doctor</u>		
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) _____			Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
PARENTS	NAME OF FATHER _____		(Signed) <u>RC Howlett</u> M. D.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		_____, 191____ (Address) <u>Howlett</u>		
	MAIDEN NAME OF MOTHER _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Satisfactory Information Supplied.</u>			Where was disease contracted if not at place of death? _____ Former or usual residence _____		
(ADDRESS) _____			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191____		
Filed <u>11/5</u> , 191 <u>9</u> <u>RC Howlett</u> REGISTRAR			UNDERTAKER _____ ADDRESS _____		

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

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