

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.

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

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

Registration District No. 1039 File No. 158456  
Primary Registration District No. 5010 Registered No. 18

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

FULL NAME Gail Harmon

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> (If write the words)	DATE OF DEATH <u>Dec 24</u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Jan 29</u> , 19 <u>04</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Dec 22</u> , 191 <u>3</u> , to <u>Dec 24</u> , 191 <u>3</u> , that I last saw him alive on <u>Dec 23</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at <u>6:30</u> am.	
AGE <u>9</u> yrs. <u>10</u> mos. <u>26</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Septicemia</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			<u>W</u> <u>36</u> (Duration) ___ yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Adair Mo</u>			Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.	
PARENTS	NAME OF FATHER <u>Chas Harmon</u>		(Signed) <u>W Harmon</u> M. D.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Adair Mo</u>		<u>Dec 24</u> , 191 <u>3</u> (Address) <u>Greencastle</u>	
	MAIDEN NAME OF MOTHER <u>May Williams</u>		*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) <u>Adair Mo</u>		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>W Harmon</u> (ADDRESS) <u>Green Castle</u>			Where was disease contracted if not at place of death? Former or usual residence _____	
Filed <u>Dec 27</u> , 191 <u>3</u> <u>Jas H Reed</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Greencastle County</u> DATE OF BURIAL <u>12/25</u> , 191 <u>3</u> UNDERTAKER <u>W H Crump</u> ADDRESS <u>Greencastle</u>	

# 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.)



MAR 1913  
 READING INK  
 FOR BINDING  
 PERMANENT RECORD

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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 Adair  
 County Adair  
 Township Honow Registration District No. 1039 File No. \_\_\_\_\_  
 or \_\_\_\_\_  
 Village \_\_\_\_\_ Primary Registration District No. 5010 Registered No. 18  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

FULL NAME Gail Haman

(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>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> (Write the word)	DATE OF DEATH <u>Dec 24</u> , 191 <u>3</u> (Month) (Day) (Year)		
DATE OF BIRTH _____, _____, _____ (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from _____, 191 <u>3</u> , to _____, 191 <u>3</u> , that I last saw her alive on _____, 191 <u>3</u> , and that death occurred, on the date stated above, at <u>6:30</u> m.		
AGE _____ yrs. _____ mos. _____ ds.			The CAUSE OF DEATH* was as follows: <u>pts. Cemia</u>		
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) _____			(Duration) _____ yrs. _____ mos. _____ ds.		
PARENTS	NAME OF FATHER _____		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		(Signed) <u>Wm Parsons</u> M. D. <u>12/24</u> 191 <u>3</u> (Address) <u>Granada</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) _____ (ADDRESS) _____			Where was disease contracted if not at place of death? Former or usual residence _____		
Filed <u>12/27</u> 191 <u>3</u> <u>3-10</u> <u>Gas 12 Road</u> REGISTRAR <u>W. H. ...</u>			PLACE OF BURIAL OR REMOVAL _____		DATE OF BURIAL _____ 191 <u>3</u>
			UNDERTAKER <u>W. H. ...</u>		ADDRESS <u>Granada</u>

Original file, date DE 1913 19 \_\_\_\_\_ All information called for must be written on this Supplementary Certificate.

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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 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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