

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

PLACE OF DEATH:

County Greehe  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Springfield (No. 625 Page Ave. St. \_\_\_\_\_ Ward);

Registration District No. 318 File No. 39147  
Primary Registration District No. 2001 Registered No. 635

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

FULL NAME: Bruce E.E. Detlor

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Child

DATE OF DEATH Dec. 3rd, 1913  
(Month) (Day) (Year)

DATE OF BIRTH Aug. 21, 1911  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended, deceased from Nov. 30th, 1913, to Dec. 3rd, 1913, that I last saw him alive on Dec. 3rd, 1913, and that death occurred, on the date stated above, at 11:30 p.m.

AGE 2 yrs. 3 mos. ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:  
Basilar Meningitis  
186A  
54E  
03B

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

BIRTHPLACE (City or town, State or foreign country) Monett, Mo.

(Duration) yrs. mos. ds.  
Contributory Present in face with severe pneumonia  
(Duration) yrs. mos. ds.

NAME OF FATHER Frank T. Detlor

(Signed) W. P. Patterson M. D.  
Dec. 5th, 1913 (Address) Springfield, Mo.

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

MAIDEN NAME OF MOTHER Edna H. Cowan

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Greene Co. 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. J. Detlor  
(ADDRESS) 625 Page, City

PLACE OF BURIAL OR REMOVAL Maple Park Cem. DATE OF BURIAL Dec. 5th, 1913

Filed Dec 5, 1913 W. C. Smith REGISTRAR

UNDERTAKER Will C. Lohmeyer ADDRESS 505 W. Walnut

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.

# 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.)

CAUSES 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 CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH Emur County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City Springfield (NO. 625 Payne St.: \_\_\_\_\_ Ward) \_\_\_\_\_  
 Registration District No. 318 File No. \_\_\_\_\_  
 Primary Registration District No. 2001 Registered No. 635  
 FULL NAME Bruce E. E. Better (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<br><u>M</u>   | COLOR OR RACE<br><u>w</u>  | SINGLE MARRIED WIDOWED OR DIVORCED<br>(Write the word)<br><u>S</u> |
| DATE OF BIRTH<br>_____, <u>1</u> (Month) _____ (Day) _____ (Year)   |  |  |
| AGE<br>____ yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.  |  |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>(b) General nature of industry, business, or establishment in which employed (or employer) |  |  |
| BIRTHPLACE<br>(City or town, State or foreign country)  |  |  |
| PARENTS   | NAME OF FATHER   |  |
|   | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) |  |
|   | MAIDEN NAME OF MOTHER  |  |
|   | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) _____<br>(ADDRESS) _____   |  |  |
| Filed <u>175</u> 191 <u>3</u> _____ REGISTRAR   |  |  |

DATE OF DEATH 17/3, 1913  
 (Month) (Day) (Year)

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

The CAUSE OF DEATH\* was as follows:  
Basillar Meningitis  
Puncture wound of face penetrating the cranium - made by falling on point of scissors  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
 Contributory Wound in face with knife  
 (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
 (Signed) W. P. Patterson M. D.  
175, 1913 (Address) Springfield Mo

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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 \_\_\_\_\_ 1913

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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