

Every item of information should be carefully checked and should be stated EXACTLY. PHYSICIANS at CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

PLACE OF DEATH

MISSOURI STATE BOARD OF BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

County _____ File No. _____
 Township _____ Registration District No. _____ Registered No. _____
 or _____
 Village _____ Primary Registration District No. _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (# rids the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)		
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?

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) _____

Filed _____

191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attie
 _____, 191 _____, to
 that I last saw h _____ alive on _____
 and that death occurred, on the date state
 The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs.

Contributory _____

(SECONDARY) (Duration) _____ yrs

(Signed) _____

191 _____ (Address) _____

*State the Disease Causing Death, or, in deal
 (1) Means of Injury; and (2) whether Accidental, Self

LENGTH OF RESIDENCE (FOR HOSPITALS, I
 RECENT RESIDENTS)

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

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____

UNDERTAKER _____

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

NOTE: Item of information should be given EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County <u>Murcer</u>			REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.		
Township <u>Marion</u>			Registration District No. <u>1553</u>	File No. _____	
Village _____			Primary Registration District No. _____	Registered No. _____	
City _____			(NO. _____ St. _____ Ward _____)	(If death occurred in a hospital or institution, give its NAME instead of street and number)	
FULL NAME <u>George H Acton</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (If write the word)	DATE OF DEATH <u>Sept 18</u> 191 <u>3</u> (Month) (Day) (Year)		
DATE OF BIRTH _____ (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.		
AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. _____ min.			The CAUSE OF DEATH was as follows: <u>Cerebral Hemorrhage</u> <u>due to hardening of Cerebral Arteries</u>		
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory <u>Bright's Disease</u> (Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) _____			(Signed) <u>Ed. E. Evans</u> M. D. <u>9/23</u> 191____ (Address) <u>Murcer Mo</u>		
PARENTS	NAME OF FATHER _____		*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 FATHER (City or town, State or foreign country) _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	MAIDEN NAME OF MOTHER _____		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		Where was disease contracted if not at place of death? _____		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) _____					
(ADDRESS) _____					
Filed <u>24/8</u> 191 <u>4</u>			REGISTRAR <u>J. E. Lane</u>		
			PLACE OF BURIAL OR REMOVAL _____	DATE OF BURIAL _____ 191____	
			UNDERTAKER _____	ADDRESS _____	

Original file, date _____, 19____ All information called for must be written on this Supplementary Certificate.

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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