

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 St Charles  
 County St Charles Registration District No. 758 File No. 406505  
 Township Cecivore or Village \_\_\_\_\_ Primary Registration District No. 5999 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

FULL NAME Kingy B. Holder

[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>Male</u>  | COLOR OR RACE<br><u>Black</u>   | SINGLE MARRIED WIDOWED OR DIVORCED<br>(Write the word) <u>Single</u> | DATE OF DEATH<br><u>Dec. 3, 1913</u><br>(Month) (Day) (Year)   |  |
| DATE OF BIRTH<br><u>Oct 27, 1883</u><br>(Month) (Day) (Year)  |   |  | I HEREBY CERTIFY, that I attended deceased from<br><u>Oct. 13, 1913</u> , to <u>Dec 3, 1913</u> ,<br>that I last saw him alive on <u>Nov. 29, 1913</u> ,<br>and that death occurred, on the date stated above, at <u>6 a. m.</u><br>The CAUSE OF DEATH* was as follows:<br><u>Tuberculosis</u> |  |
| AGE<br><u>30 yrs. 1 mos. 6 ds.</u>  |   | if LESS than<br>1 day, ___ hrs.<br>or ___ min.?                      | 23H<br>(Duration) <u>22</u> yrs. ___ mos. ___ ds.  |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work<br><u>Laborer</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |   |  | Contributory<br>(SECONDARY)<br>(Duration) ___ yrs. ___ mos. ___ ds.  |  |
| BIRTHPLACE<br>(City or town, State or foreign country)<br><u>Hannibal Mo</u>  |   |  | (Signed) <u>H. W. Rosley</u> M. D.<br><u>Dec 3, 1913</u> (Address) <u>5th &amp; 2nd Sts.</u>   |  |
| PARENTS   | NAME OF FATHER<br><u>Bonny Halde</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 FATHER<br>(City or town, State or foreign country)<br><u>Unknown</u>  |  |  |  |
|   | MAIDEN NAME OF MOTHER<br><u>Lizzie Martin</u>                                       |  |  |  |
|   | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country)<br><u>Hannibal</u> |  |  |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Bessie Miller</u><br>(ADDRESS) <u>Wrightville Mo.</u>   |   |  | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.<br>Where was disease contracted if not at place of death?<br>Former or usual residence _____                          |  |
| Filed <u>Dec. 5, 1913</u> <u>J. A. Reed</u> REGISTRAR   |   |  | PLACE OF BURIAL OR REMOVAL<br><u>Lincoln Co.</u> DATE OF BURIAL<br><u>Dec 5, 1913</u>  |  |
|   |   |  | UNDERTAKER<br><u>M. C. Ball</u> ADDRESS<br><u>Hannibal, Mo.</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.)



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 St Charles  
 County Quinn  
 Township \_\_\_\_\_  
 or \_\_\_\_\_  
 Village \_\_\_\_\_  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 758 File No. \_\_\_\_\_  
 Primary Registration District No. 5999 Registered No. 40

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

FULL NAME Kugy. B. Holder

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE B SINGLE 8 MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH DEC 3 1913  
 (Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from DEC 3, 1913, to DEC 3, 1913, that I last saw him alive on 11/29, 1913, and that death occurred, on the date stated above, at 6 m.

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

The CAUSE OF DEATH\* was as follows:

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

Tuberculosis of the lungs  
 (Duration) one yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Contributory (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER \_\_\_\_\_

(Signed) D. H. Reid M.D. 1913 (Address) St Charles Mo

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

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

MAIDEN NAME OF MOTHER \_\_\_\_\_

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

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

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death? \_\_\_\_\_

(Informant) \_\_\_\_\_

Former or usual residence \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

Filed \_\_\_\_\_ 191\_\_\_\_ J. A. Reid REGISTRAR

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

N. B.—Every item of information should be carefully classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be classified. Exact statement of OCCUPATION is very important.

Supplementary Information supplied by Registrars

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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.)