

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 Republ.
Township Grant
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 264 File No. 639
Primary Registration District No. 9367 Registered No. 4
(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Joseph Leroy Shuman

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If wife the word)

DATE OF BIRTH Dec 15, 1913
(Month) (Day) (Year)

AGE 0 yrs. 0 mos. 21 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) MO

PARENTS
NAME OF FATHER B. Harry Shuman
BIRTHPLACE OF FATHER (City or town, State or foreign country) MO
MAIDEN NAME OF MOTHER Fannie Taylor
BIRTHPLACE OF MOTHER (City or town, State or foreign country) MO

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Shuman
(ADDRESS) Frederick St. M. L. Richey

Filed Jan 2 1914 L. A. Richey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 5, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 4, 1914, to Jan 15, 1914, that I last saw him alive on Jan 15, 1914, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:
Acute Enterocolitis

117B (Duration) 10 yrs. 10 mos. 5 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) [Signature] M. D.
1914 (Address) [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 Woodlawn DATE OF BURIAL Jan 6 1914
UNDERTAKER [Signature] ADDRESS [Address]

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.)



PLACE OF DEATH

County

Dephaly
*Grant*REGISTRARS SHALL NOT RE-
CEIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

Registration District No.

264

File No.

639

Township

or

Village

or

City

(NO.

Primary Registration District No.

5367

Registered No.

4

St.: _____ Ward)

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

FULL NAME

Joseph L. Sheraul

PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

*W*SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)*S*

DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

AGE

If LESS than
1 day, _____ hrs.
or _____ min.

_____ yrs. _____ mos. _____ ds.

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) _____

PARENTS

NAME OF
FATHERBIRTHPLACE
OF FATHER
(City or town, State or foreign country)MAIDEN NAME
OF MOTHERBIRTHPLACE
OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed

Jan 12 1914

1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from

191____, to _____, 191____,

that I last saw him _____ on _____, 191____,

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

The CAUSE OF DEATH* was as follows:

Contributory _____

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

_____ M. D.

_____ 1914 (Address) _____

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(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 _____ 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

191____

UNDERTAKER

ADDRESS

Original file, date

Jan -

1914

information called for must be written on this Supplementary Certificate.

MARGIN RESERVED FOR THIS IS A P.E.

AD

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SATISFACTORY INFORMATION SUPPLIED

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