

PLACE OF DEATH
 County Adair
 Township Walnut
 or
 Village
 or
 City (NO. St. Word)

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

Registration District No. 1064 File No. 3 3773
 Primary Registration District No. 3009 Registered No. 3

FULL NAME Fredrick Martsof

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Widowed
 DATE OF BIRTH June 11 1883
 (Month) (Day) (Year)
 AGE 78 yrs 7 mos 23 ds.
 If LESS than 1 day, hrs. or min.?

MEDICAL CERTIFICATE OF DEATH
 DATE OF DEATH Feb 4 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 4, 1914, to Feb 4, 1914, that I last saw him alive on Feb 4, 1914, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH was as follows:
Neuralgia of the Heart
9411

Contributory (SECONDARY)
 (Duration) yrs. mos. ds.
 (Signed) R. S. Shepley M. D.
 1914 Address Wilson

*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)
 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 Union Temple DATE OF BURIAL Feb 6 1914
 UNDER-TAKER C. Wilson Kirkwood ADDRESS

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) Farming
 BIRTHPLACE (City or town, State or foreign country) Germany
 NAME OF FATHER Phillip Martsof
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
 MAIDEN NAME OF MOTHER Don't know
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) A. T. Sewell
 (ADDRESS) youngstown
 Filed Feb 12 1914 Registrar Oscar H. Habber

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.

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WRITE PLAINLY, WITH UNFADING INK

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

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.) Registration District No. File No.
 Primary Registration District No. Registered No.
 St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)	(Day)
AGE yrs. mos. ds.	(Year)
OCCUPATION	IF LESS than 1 day, hrs. or min. ?	
BIRTHPLACE	(City or town, State or foreign country)	
NAME OF FATHER	PARENTS	
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)

Filled

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to

....., 191....., to

that I last saw h..... alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY)

(Duration)

(Signed)

(Duration)

(Address)

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

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

At place of death..... yrs. mos. ds. 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

UNDERTAKER

ADDRESS below

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County Adair
 Township Walnut
 or
 Village
 or
 City

Registration District No. 1067
 Primary Registration District No. 5009

File No. _____
 Registered No. _____

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

FULL NAME

Fredrick Matsrey

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
DATE OF BIRTH _____, 191____ (Month) (Day) (Year)		
AGE _____, Yes 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)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb - 4, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914, that I last saw him alive on _____, 1914, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
neurabgion of heart

Contributory (SECONDARY)
 (Duration) yrs. mos. ds.
 (Signed) R. H. Shepler M. D.
9-2, 1914 (Address) Green City Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, (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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

REGISTRAR

Original file, date

Feb 14 1914

All information called for must be written on this Supplementary Certificate.

Age called for. AGE should be stated EXACTLY. PHYSICIANS should state exactly, and properly classified. Exact statement of OCCUPATION is very important.

Satisfactory Information Supplied

SUPPLEMENTARY

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Satisfactory Information Supplied

Satisfactory Information Supplied

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*, *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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