

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

PLACE OF DEATH  
County Cape Girardeau  
Township Liberty  
or  
Village  
or  
City (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 130 File No. 4148  
Primary Registration District No. 5181 Registered No. 2

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

FULL NAME Alexander Welker

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED married  
WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH Oct 15, 1882  
(Month) (Day) (Year)  
AGE 32 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work Farming  
(b) General nature of industry, business, or establishment in which employed (or employer)

DATE OF DEATH Feb 8, 1914  
(Month) (Day) (Year)  
I HEREBY CERTIFY, that I attended deceased from Feb 29, 1914, to Feb 8, 1914, that I last saw him alive on Feb 8, 1914, and that death occurred, on the date stated above, at 4 P. m.  
The CAUSE OF DEATH\* was as follows:  
Pneumonia

BIRTHPLACE (City or town, State or foreign country) Cape Girardeau Co.  
PARENTS  
NAME OF FATHER Benjamin Welker  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Cape Girardeau Co.  
MAIDEN NAME OF MOTHER Jane Clay  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.  
Contributory (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) J. M. Parnell M. D.  
Feb 8, 1914 (Address) Whitewater 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) Conder Welker  
(ADDRESS) Whitewater Mo.  
Filed Feb 20, 1914 A. M. Neuberger  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Barber Cemetery DATE OF BURIAL Feb 9, 1914  
UNDERTAKER W. H. Hinton ADDRESS Allenville Mo.

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

**PLACE OF DEATH**

County \_\_\_\_\_  
 Township \_\_\_\_\_  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_

Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registered No. \_\_\_\_\_

(NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	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

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

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

**MEDICAL CERTIFICATE OF DEATH**

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

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h \_\_\_\_\_ alive 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) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Address) \_\_\_\_\_ 191\_\_\_\_ M. D.

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_

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

CAUSE OF DEATH: If death occurred in a hospital or institution, give its name instead of street and number. If death occurred elsewhere, state the place where it occurred. If death occurred in a hospital or institution, give its name instead of street and number. If death occurred elsewhere, state the place where it occurred. If death occurred in a hospital or institution, give its name instead of street and number. If death occurred elsewhere, state the place where it occurred.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item on this form is required to be filled in. If a space is left blank, it will be assumed that the information is not available. If a space is left blank, it will be assumed that the information is not available. If a space is left blank, it will be assumed that the information is not available.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

PLACE OF DEATH Cape Gir  
County Liberty  
Township \_\_\_\_\_ Registration District No. 130 File No. \_\_\_\_\_  
or \_\_\_\_\_ Primary Registration District No. 5181 Registered No. 3  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Alexander Wecker

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE M  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write 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)

PARENTS  
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 7/20 1914 A. M. Murphy  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 7/8 1914  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

I HEREBY CERTIFY, that I attended deceased from  
Satisfactory Information Supplied.  
that I last saw him alive on \_\_\_\_\_, 1914,  
and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH\* was as follows:  
Pneumonia  
Lobar.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.

Contributory  
(SECONDARY)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Signed J. M. Ginsy M. D.  
7/8 1914 (Address) White Water

\*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 Barker Chapel DATE OF BURIAL \_\_\_\_\_ 1914

UNDERTAKER J. M. Ginsy ADDRESS Allen

# 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*, *peritonaeum*, 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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