

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

PLACE OF DEATH
County Scott
Township _____
or
Village Vanduser
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 1157 File No. 7042
Primary Registration District No. 4587 Registered No. _____

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

FULL NAME John Franklin Thompson

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Month 5, 21 1913
(Month) (Day) (Year)
AGE 11 yrs. 17 mos. 17 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) Scott Co Mo

PARENTS
NAME OF FATHER John Thompson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Scott Co Mo
MAIDEN NAME OF MOTHER Anna May Chilton
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Scott Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Thompson
(ADDRESS) Vanduser Mo

Filed 2/27 1914 A. G. Steph
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 22, 1914
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Jan 29, 1913, to Feb 22, 1914
that I last saw him alive on Feb 20, 1914
and that death occurred, on the date stated above, at 5.9 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia
107A

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. A. Cline M. D.
2/26 1914 (Address) Cran 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 _____

PLACE OF BURIAL OR REMOVAL Merley Cem DATE OF BURIAL 2/23 1914
UNDERTAKER E. O. Sexton ADDRESS Vanduser

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.

RECORD WITH ONE COPY TO THE STATE BOARD OF HEALTH

PLACE OF DEATH

County.....
 Township.....
 or
 Village.....
 or
 City..... (NO.)

Registration District No.
 Primary Registration District No.

File No.
 Registered No.

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH, 191..... (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:

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

Contributory..... (SECONDARY), 191..... (Address), 191..... (Signed)

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

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. State, 191..... In the, 191.....
 Where was disease contracted if not at place of death?, 191.....
 Former or usual residence

PLACE OF BURIAL OR REMOVAL, 191..... DATE OF BURIAL, 191.....

UNDERTAKER, 191..... ADDRESS, 191.....

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, 191..... REGISTRAR

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.

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

CERTIFICATE OF DEATH

PLACE OF DEATH

County Scott

Township Nauduser

Village Nauduser

City _____

Registration District No. 1157

Primary Registration District No. 4589

File No. _____

Registered No. _____

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

FULL NAME John Franklin Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH _____, 1914
(Month) _____ (Day) _____ (Year)

DATE OF BIRTH _____, 1914
(Month) _____ (Day) _____ (Year)

SAY HEREBY CERTIFY, that I attended deceased from _____, 1914, to _____, 1914,
that I last saw h. _____ alive on _____, 1914,
and that death occurred, on the date stated above, at 500 m.

AGE _____ yrs. _____ mos. _____ ds.
If LESS than 1 day, _____ hrs. _____ min.

The CAUSE OF DEATH* was as follows:
Pneumonia Bronch

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (of 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 7/27 1914 H A L Stepp
REGISTRAR

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

(Signed) J. A. Clark M. D.
1914 (Address) Oran 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 _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1914

UNDERTAKER E. A. Sexton ADDRESS Nauduser Mo

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.

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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