

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

PLACE OF DEATH  
County Stoddard

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Berrie

Registration District No. 836  
Primary Registration District No. 4507

File No. 7090  
Registered No. 10

FULL NAME Earnest V. Parker

[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 single  
(Write the word)

DATE OF BIRTH March 24, 1913  
(Month) (Day) (Year)

AGE 10 yrs. 10 mos. 27 ds.  
If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work none 179E  
(b) General nature of industry, business, or establishment in which employed (or employer) 805 GVA

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Feb. 21, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 21, 1914, to Feb. 21, 1914, that I last saw him alive on Feb. 21, 1914, and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH\* was as follows:  
Acute congestion of brain and spinal cord.

BIRTHPLACE (City or town, State or foreign country) Berrie, Mo.

PARENTS

NAME OF FATHER Thomas Murre Parker  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Missouri

MAIDEN NAME OF MOTHER May Medler  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Illinois

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

(Signed) T. C. Allen M. D.  
2/21, 1914 (Address) Berrie, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) G. M. Parker  
(ADDRESS) Berrie, 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 \_\_\_\_\_

Filed 2/21, 1914 H. T. Allen  
REGISTRAR

PLACE OF BURIAL OR REMOVAL Berrie, Mo  
DATE OF BURIAL 2/22, 1914

UNDERTAKER M. J. Hadley  
ADDRESS Berrie, 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.)

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

PLACE OF DEATH Stoddard  
 County Stoddard  
 Township \_\_\_\_\_  
 or Village \_\_\_\_\_  
 or City Berrie (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 836 File No. \_\_\_\_\_  
 Primary Registration District No. 4507 Registered No. 10

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

FULL NAME Ernest N Parker

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S  
(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) \_\_\_\_\_  
 File 7/21 1914 H. Callen 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 h. \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Acute Impression of Brain  
and cerebral End - died 10 min  
after reaching my office.  
Since making certificate  
I have learned that it acci-  
dentally ate some strychnine  
tablets - (Chick)  
 Contributory \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Address) 4 Gallen

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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 \_\_\_\_\_

Satisfactory Information Supplied \_\_\_\_\_  
 SUPPLEMENTARY INFORMATION Supplied \_\_\_\_\_  
 Satisfactory Information Supplied \_\_\_\_\_

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