

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

Dr. Case

County

Greene

Township

Registration District No.

318

File No.

8222

or Village

Primary Registration District No.

~~318~~ *5740*

Registered No.

188

or City

(NO. _____)

4 miles S. West

Ward

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

FULL NAME

Mr. G. M. Rouster

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

m

w

single

DATE OF BIRTH

Oct.

(Month)

(Day)

1841
(Year)

AGE

73 yrs.

5 mos.

— ds.

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

OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

Mo.

NAME OF FATHER

G. M. Rouster

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Mo.

MAIDEN NAME OF MOTHER

Levit Brown

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

453 S. Market

Filed

Mar 24 1914

D. C. W. Smith

REGISTRAR

DATE OF DEATH

Mar. 23 - 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Mar 21, 1914, to Mar 23, 1914,

that I last saw him live on *Mar 21, 1914,*

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

The CAUSE OF DEATH[†] was as follows:

Paralysis
87 A
87 D

(Duration) _____ yrs. _____ mos. *3* ds.

Contributory

Previous attack

(SECONDARY)

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

(Signed)

J. V. B. Crane

M. D.

Apr 1, 1914 (Address) *318 1/2 Alley*

[†]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

Rouster's Care

DATE OF BURIAL

3-24-1914

UNDERTAKER

W. C. Gentry

ADDRESS

478 W. Walnut St.

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.)

PLACE OF DEATH

County

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

Township

Registration District No.

File No.

or Village

Primary Registration District No.

Registered No.

or City

(NO.

St.

Ward)

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

FULL NAME

N. M. Roumtrm

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 19____
(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 *3/24* 1914 *D. C. Smith* REGISTRAR
April 22, 14

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 19____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, that I last saw _____, 19____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Analysis Hemiplegia gradually becoming complete in 3 days
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory *Pneumonia*
(Secondary) _____ yrs. _____ mos. _____ ds. (Duration) _____
(Signed) *J. B. Ormer* M. D.
411 1914 (Address) *318 1/2 E. 11th*

*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 *Saturday* _____ 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 _____ 19____

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.

Satisfactory Information Supplied.

CAUSE OF DEATH

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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