

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

3. 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
County Polk
Township Union
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 700 File No. 9631 5
Primary Registration District No. 6249 Registered No. 5

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

FULL NAME William L Harrison

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OF RACE White SINGLE MARRIED Married
WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Oct 30, 1842
(Month) (Day) (Year)

AGE 71 yrs. 4 mos. 25 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) same

BIRTHPLACE (City or town, State or foreign country) Ill

PARENTS
NAME OF FATHER John Harrison
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ind
MAIDEN NAME OF MOTHER Ruth Pemberton
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Harrison
(ADDRESS) Aldrich Mo

Filed 3/26 1914 W. M. Laughlin M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 25, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 19, 1914, to March 24, 1914, that I last saw him alive on March 24, 1914, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ___ yrs. ___ mos. 7 ds.
Contributory (SECONDARY) None
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) W. M. Laughlin M. D.
March 26, 1914 (Address) _____

*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 Shady Grove Mo
DATE OF BURIAL 3-26 1914

UNDERTAKER Thos McColl ADDRESS Aldrich Mo

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

PLACE OF DEATH
County.....

Township..... File No.....
or
Village..... Registration District No.....
or
City..... (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 (If wife, the word)
DATE OF BIRTH	(Month)	(Day)
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)

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

MEDICAL CERTIFICATE OF DEATH

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

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

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

(Signed)..... 191..... (Address)
..... 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..... yrs. mos. ds.

Where was disease contracted if not at place of death?
Former or usual residence.....

PLACE OF BURIAL OR REMOVAL
..... 191.....

UNDERTAKER
..... ADDRESS

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
 County Polk
 Township Union
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 700 File No. _____
 Primary Registration District No. 6249 Registered No. 5

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

FULL NAME William L. Harrison

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. _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employed) _____

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 3/26 1914 W. L. Harrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/25 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____ that I last saw him _____ alive on _____, 1914.

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

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Signed) AW M. D. (Address) _____

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

(Signed) 3/26 1914 (Address) _____

*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 _____ 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 _____ ADDRESS _____

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.

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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

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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.)