

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

PLACE OF DEATH
County Francis
Township Randolph
or
Village Ladwood
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 33
Primary Registration District No. 6074B

File No. 13698-a
Registered No. 34

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

FULL NAME Vladimir Pavlov

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED single
(If write the word)
DATE OF BIRTH August 17, 1913
(Month) (Day) (Year)
AGE 9 yrs. 19 mos. 19 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) Polish

PARENTS
NAME OF FATHER John Pavlov
BIRTHPLACE OF FATHER (City or town, State or foreign country) Polish
MAIDEN NAME OF MOTHER Pavlova
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Polish

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jan Pavlov
(ADDRESS) Ladwood Md

Filed Apr 16, 1914 Rappley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 16, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 10, 1914, to April 16, 1914, that I last saw him alive on April 12, 1914, and that death occurred, on the date stated above, at 6:30 am.

The CAUSE OF DEATH* was as follows:
42 A Pneumonia

Contributory Valvular Insufficiency
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Jan W. Rappley M. D.
Apr 16, 1914 (Address) Ladwood Md

*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 Ladwood Cemetery DATE OF BURIAL Apr 17, 1914
UNDERTAKER J. J. Rappley ADDRESS Ladwood Md

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, 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 *septicæmia*," "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 COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH

County St. Francois
 or
 Township Randolph
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 33 File No. _____
 Primary Registration District No. 6094B Registered No. 34

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

FULL NAME

Nendykar Paek

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 191____
(Month) (Day) (Year)

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

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 Apr 16 1914 L. Roppberg REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 16, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him on _____, 191____, and that death occurred, on the date stated above, at 5:30 a.m.

Satisfactory Information Supplied
 The CAUSE OF DEATH* was as follows:
Pneumonia Toxica

Contributory Valvular Insufficiency
(SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Geo W Huffman M. D.
Apr 16, 1914 (Address) Leadswood 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. State _____ yrs. _____ mos. _____ ds.
 Where did 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

Satisfactory Information Supplied

Satisfactory Information Supplied

CAUTION: BE CAREFUL IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE PLACE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

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Association]

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