

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
County Centry
Township Jackson
or
Village
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 946 File No. 15840
Primary Registration District No. 482, B Registered No. _____

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

FULL NAME Jacob Sadler

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
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DATE OF BIRTH Sept 26, 1870
(Month) (Day) (Year)

AGE 43 yrs. 8 mos. 2 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) _____

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

PARENTS	NAME OF FATHER <u>Med Sadler</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>
	MAIDEN NAME OF MOTHER <u>Dora Brown</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Sadler
(ADDRESS) King City Mo

Filed May 30 1914. P. H. Guisenberg
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 28, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 27, 1914, to May 28, 1914, that I last saw him alive on May 28, 1914, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia lobular

97 131 107A
(Duration) _____ yrs. _____ mos. 7 ds.

Contributory Nephritis
(SECONDARY) (Duration) 2 yrs. _____ mos. _____ ds.

(Signed) W. Paullette M. D.
May 29, 1914 (Address) King City 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 King City Mo DATE OF BURIAL May 30, 1914

UNDERTAKER W. L. & E. Cole ADDRESS King City, Mo.

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

N. B.—Every item of information should be properly classified. CAUSE OF DEATH in plain terms, as stated by the attending physician, should state the disease, and its duration, if very important.

County _____
 Township _____ File No. _____
 or Village _____ Registration District No. _____
 or _____ Primary Registration District No. _____
 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 (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) _____

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 _____ (Month) _____ (Day) _____ (Year) _____, 191____

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.

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

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

Contributory
 (SECONDARY)

(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	DATE OF BURIAL
_____	_____ 191____
UNDERTAKER	ADDRESS
_____	_____

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH Country
County Jackson REGISTRARS SHALL NOT RE-
Township _____ GIVE A FEE FOR CERTIFICATED
or _____ UNTIL THEY ARE COMPLETED AS
Village _____ PRESCRIBED BY THE BOARD
or _____ Registration District No. 945 File No. _____
City _____ (NO. _____) St. _____ Ward _____
Primary Registration District No. 848213 Registered No. _____

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

FULL NAME Jacob Sadler

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE _____ yrs. _____ mos. _____
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 May 30 1914 P. H. Quisenberry
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 28, 1914
(Month) _____ (Day) _____ (Year) _____

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

THE CAUSE OF DEATH* was as follows:
Pneumonia Lobular.

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

(Signed) 5/29 1914 (Address) King City Mo 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. 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 Gossard

SATISFACTORY INFORMATION SUPPLIED.

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

N. B. CAUSE OF DEATH AND PLACE OF DEATH ARE VERY IMPORTANT. OCCUPATION IS ALSO VERY IMPORTANT. BE CAREFUL IN FILLING OUT THIS FORM. BE CAREFUL IN FILLING OUT THIS FORM. BE CAREFUL IN FILLING OUT THIS FORM.

Original file, date MAY - 1914, 19____

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 "*Asihenia*," "*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 septichaemia*," "*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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