

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 *Stoddard* ✓
County *Stoddard*
Township *Richland* Registration District No. *839* File No. *18274*
or *to*
Village *to* Primary Registration District No. *6101* Registered No. *26*
or
City _____ St. _____ Ward _____

FULL NAME *Albert W. Waters*

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *M* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *Single*
DATE OF BIRTH *Jan 16 1894*
(Month) (Day) (Year)
AGE *20* yrs. *3* mos. *27* ds. IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work *Comm. Labor*
(b) General nature of industry, business, or establishment in which employed (or employer) *✓*

DATE OF DEATH *May 17 1914*
(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 *11 a.m.*

The CAUSE OF DEATH* was as follows:

Gun shot wound fired by Elvira Howlett
173
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) *Idalia Mo*

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

PARENTS NAME OF FATHER *Thomas W. Waters*
BIRTHPLACE OF FATHER (City or town, State or foreign country) *Ky.*
MAIDEN NAME OF MOTHER *Lillie Pruitt*
BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ind*

Signed *A. C. Caldwell* M. D.
5/8 1914 (Address) *Essex 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Allen Waters*
(ADDRESS) *Essex Mo*

PLACE OF BURIAL OR REMOVAL *Triplet Cem.* DATE OF BURIAL *5/8 1914*

Filed *5/8 1914* *A. C. Caldwell* REGISTRAR

UNDERTAKER *A. C. Caldwell* ADDRESS *C. O. Siggo Dexter Mo.*

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

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 COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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

Registration District No. 839 File No. _____
Primary Registration District No. 6101 Registered No. 26

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

FULL NAME Albert W Waters

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE 1
MARRIED _____
WIDOWED _____
OR DIVORCED _____
(Write the word)

DATE OF DEATH _____
_____ (Month) May _____ (Day) 7 _____ (Year) 1914

DATE OF BIRTH _____
_____ (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 _____.

AGE _____ yrs. _____ ds. or _____ mths. _____

Satisfactory Information Supplied. 11/10
The CAUSE OF DEATH was as follows:
Gun shot wound
sent by Elvia Bowler
Homicide

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) _____

Contributory (SECONDARY) _____
(Stated) _____
_____ (Address) _____

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
Gun shot wound
Homicide

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

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 _____

(ADDRESS) _____
MAY 8 1914
REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____
UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

18271
h12281

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