

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

PLACE OF DEATH

County Linn

Township \_\_\_\_\_

or Village \_\_\_\_\_

or City Linneus Mo. (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 1501

File No. 19857

Primary Registration District No. 4304

Registered No. 14

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

FULL NAME William Stephens.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE Black SINGLE MARRIED WIDOWED OR DIVORCED Single (Write the word)

DATE OF DEATH July 20, 1914 (Month) (Day) (Year)

DATE OF BIRTH Sept 4th 1880 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 20, 1914, to June 20, 1914, that I last saw him alive on June 20, 1914, and that death occurred, on the date stated above, at 2 m.

AGE 33 yrs. 9 mos. 2 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH<sup>†</sup> was as follows:

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

Gun shot wound  
striking spinal column  
Cord  
17 1/2 (Duration) yrs. mos. ds.

BIRTHPLACE (City or town, State or foreign country) #### Iowa.

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

PARENTS NAME OF FATHER William Stephens BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't know MAIDEN NAME OF MOTHER Trumbo. BIRTHPLACE OF MOTHER (City or town, State or foreign country) MO.

(Address) L. O. Home M. D. Linneus

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Lygia Rucker (ADDRESS) Linneus Mo.

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 \_\_\_\_\_

Filed June 21, 1914, W. C. Travis REGISTRAR

PLACE OF BURIAL OR REMOVAL Linneus Mo. DATE OF BURIAL 8/21/14, 1914

UNDERTAKER W. C. Travis ADDRESS Linneus Mo.

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.

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PLACE OF DEATH

County \_\_\_\_\_  
Township \_\_\_\_\_  
or Village \_\_\_\_\_  
or City \_\_\_\_\_  
Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_  
(NO. \_\_\_\_\_)

[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 write the word)  
DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (Year)  
IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ 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)

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) \_\_\_\_\_, 191\_\_\_\_ (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 \_\_\_\_\_, Mo.

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY)  
(Signed) \_\_\_\_\_ (Address) \_\_\_\_\_, 191\_\_\_\_ (Address)  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. M. D.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\*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 \_\_\_\_\_

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

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

PLACE OF DEATH  
*Leinn*  
County  
Township  
or  
Village  
or  
City *Leuners* (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. *501* File No. \_\_\_\_\_  
Primary Registration District No. *4304* Registered No. *14*

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

FULL NAME *William Stephens*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH *June 20*, 191*4*  
(Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191*4* to \_\_\_\_\_, 191*4*, that I last saw him alive on \_\_\_\_\_, 191*4*, and that death occurred, on the date stated above, at *12* m.

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

CAUSE OF DEATH was as follows:  
*Gun shot wound*  
*Army Special Police*  
*Ord. Immediate*

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 \_\_\_\_\_ (Signed) *R. O. Home* M.D. *June 21, 1914* (Address) *Leuners*

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

Filed *June 21*, 191*4* *W. R. Laws* REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191*4*  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Original may date *June*, 19*14* information called for must be written on this Supplementary Certificate.

# 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, 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.)

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.

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PLACE OF DEATH

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County Linn Registration District No. 501 File No. 19857  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or \_\_\_\_\_ Primary Registration District No. 4304 Registered No. 14  
 St.; \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]  
 FULL NAME William Stephens

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OF RACE B SINGLE S MARRIED S WIDOWED S OR DIVORCED S  
 (Write the word)  
 DATE OF BIRTH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)  
 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

DATE OF DEATH June 30, 1914  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

THE CAUSE OF DEATH\* was as follows:  
Bullet wound  
Army of Columbia  
Order of 1821

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Contributory (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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) \_\_\_\_\_

Signed \_\_\_\_\_ (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 \_\_\_\_\_

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

(ADDRESS) \_\_\_\_\_  
 Filed June 31, 1914 J. R. Adams REGISTRAR

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_  
 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Original file, date \_\_\_\_\_ All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

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

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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.)