

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 Buller

Township \_\_\_\_\_

Registration District No. 89

File No. 21939

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

Primary Registration District No. 1007

Registered No. 149

or  
City Poplar Bluff (NO. 309 Homer St. 3 Ward)

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

FULL NAME Stanley G. Heirlio

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) \_\_\_\_\_

DATE OF BIRTH May 29, 1913  
(Month) (Day) (Year)

AGE 1 yrs. 1 mos. 20 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) Poplar Bluff

NAME OF FATHER R. S. Lewis

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mt Vernon

MAIDEN NAME OF MOTHER Reed

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mt Vernon

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert S. Lewis

(ADDRESS) Poplar Bluff

Filed July 20, 1914, Dr. A. P. Rowe REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 19, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1913, to July 19, 1914, that I last saw him alive on July 19, 1914

and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH\* was as follows:  
Pulmonary Tuberculosis and tuberculosis of bowels

Contributory (Duration) 1 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. Williams M. D. (Address) Poplar Bluff 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 Poplar Bluff DATE OF BURIAL July 20, 1914

UNDERTAKER A. W. Iron ADDRESS P. B.

# 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*, *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 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.)

*D. M. Williamson*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. DEATH in plain terms, so that it may be properly classified.

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

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

Township \_\_\_\_\_ Registration District No. 89 File No. \_\_\_\_\_  
 or \_\_\_\_\_  
 Village Poplar Bluff Primary Registration District No. 3007 Registered No. 149  
 or \_\_\_\_\_  
 City Poplar Bluff (No. 309 Home) St.: 3 Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Stanley, G. Lewis

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S</u> <small>(Write the word)</small>
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DATE OF BIRTH \_\_\_\_\_  
(Month) (Day) (Year)

AGE \_\_\_\_\_  
IF LESS than 1 day, hrs. or min. yrs. 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 <u>Unknown</u>
	BIRTHPLACE OF MOTHER (City or town, State, or foreign country) _____

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

Filed July 20 1914 at Dr. A. R. Row  
 REGISTRAR Dr. Greer

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 19, 1914  
(Month) (Day) (Year)

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

The CAUSE OF DEATH\* was follows:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) yrs. mos. ds.  
 (Signed) \_\_\_\_\_ M. D.  
 \_\_\_\_\_, 191\_\_\_\_ (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 _____	DATE OF BURIAL _____ 191____
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UNDERTAKER _____	ADDRESS _____
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