

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED EXCEPT WHERE SHOWN OTHERWISE

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 Caldwell
Township Deponser
or Village St. Louis
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 106 File No. 21998
Primary Registration District No. 5155 Registered No. _____

FULL NAME William J. Ovin

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

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Not known</u> (Month) _____ (Day) _____ (Year) _____		
AGE <u>about 90</u> yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Tenn</u>		
PARENTS	NAME OF FATHER _____	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	
	MAIDEN NAME OF MOTHER <u>Mary Houghton</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	

2 MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from May 5, 1914, to July 28, 1914, that I last saw him alive on July 21, 1914, and that death occurred, on the date stated above, at 90 m.

The CAUSE OF DEATH* was as follows:
Chronic Cystitis
and old age
1354
1170

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

(Signed) J. W. Ovin M. D.
(Address) Not known

*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 <u>✓</u>	DATE OF BURIAL _____ 191 <u>4</u>
UNDERTAKER _____	ADDRESS <u>✓</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Hopsacker
(ADDRESS) Samuel Hopsacker
Filed _____ 1914 REGISTRAR

will not this side

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 *Houswife*, *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*, *Sar-*

coma, 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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Callaway
Township DeWasse
Village _____
City _____

Registration District No. 106 File No. _____
Primary Registration District No. 5155 Registered No. _____
St.: _____ Ward _____

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

FULL NAME William Davis (NO. _____) (St.: _____) (Ward _____)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M. COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If in this word)

DATE OF DEATH July 24, 1914
(Month) (Day) (Year)

DATE OF BIRTH Unknown, 1824
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 25, 1914, to July 24, 1914, that I last saw him alive on July 24, 1914, and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

AGE abt 90 yrs. 0 mos. 0 ds. If LESS than 1 day, ___ hrs. or ___ min.

Chronic Cystitis / old age.
(Duration) ___ yrs. ___ mos. ___ ds.

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

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) E. Pomeroy M.D. (Address) Mokane
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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) _____

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) M. Hoplicker (Address) Steedman Mo.

PLACE OF BURIAL OR REMOVAL Callaway Co. DATE OF BURIAL _____
UNDERTAKER None ADDRESS _____

Filed Aug 26, 1914 REGISTRAR A. D. Brink

Revised United States Standard Certificate of Death

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

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21998

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