

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 Laclede
 Township Eldridge
 or
 Village Eldridge
 or
 City _____ (NO. _____ St.: _____ Ward)

Registration District No. 451 File No. 23121
 Primary Registration District No. 5616 Registered No. _____

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

FULL NAME John Hunt

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED married
(If wife the word)

DATE OF BIRTH June 28, 1842
(Month) (Day) (Year)

AGE 72 yrs. 0 mos. 17 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) Tenn.

PARENTS
 NAME OF FATHER Granderson Hunt
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Virg
 MAIDEN NAME OF MOTHER Biddie Hames
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Biddie Shadri
 (ADDRESS) Ira M.O.

Filed 7/15, 1914, L. S. Payne REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Apr 16, 1914, to June 11, 1914, that I last saw him alive on June 11, 1914, and that death occurred, on the date stated above, at 8 a.m.
 The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
131 (Duration) 150 yrs. mos. ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. mos. ds.
 (Signed) L. B. Mitchell M. D.
July 15, 1914 (Address) Eldridge 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 Huft Cem. DATE OF BURIAL June 18, 1914
 UNDERTAKER James Huft ADDRESS Eldridge Mo

PLACE OF DEATH

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

County _____
 Township _____ or _____
 Village _____ or _____
 City _____ (NO. _____) _____ St. _____ Ward _____
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered 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 (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)	I _____ (Month) _____ (Day) _____ (Year), 191____, to _____ (Month) _____ (Day) _____ (Year), 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.	
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)	The CAUSE OF DEATH* was as follows:	

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 him _____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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)

Contributory
(SECONDARY)

(Signed) _____, 191____ (Address) _____ M. D.

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

(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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____

REGISTRAR _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

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
 County Laclede
 Township Eldridge
 or
 Village
 or
 City (NO _____ St. _____ Ward)

Registration District No. 451 File No. _____
 Primary Registration District No. 5616 Registered No. _____

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

FULL NAME John Hunt

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 Satisfactory Information Supplied.

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 6/15 1914 Ed O'Connell
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 12 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 _____ m. The CAUSE OF DEATH* was as follows:

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) D. Mitchell M. D.
7/15 1914 (Address) Eldridge 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 _____ DATE OF BURIAL 6/13 1914

UNDERTAKER _____ ADDRESS _____
 Satisfactory Information Supplied.

Satisfactory Information Supplied.
 SUPPLEMENTARY
 Satisfactory Information Supplied.

Original file, date JUL - 1914, 10 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]

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

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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.)