

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

23241

PLACE OF DEATH

County Macou
Township Lytle
or
Village _____
or
City Atlanta Mo.

Registration District No. 526 File No. _____
Primary Registration District No. 4317 Registered No. _____

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

FULL NAME

Geo. E. Wolf

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
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DATE OF BIRTH May 8, 1863
(Month) (Day) (Year)

AGE 51 yrs. 2 mos. 7 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) Ohio

PARENTS	NAME OF FATHER <u>Mike Wolf</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>
	MAIDEN NAME OF MOTHER <u>Marguerite Bush</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dan Norrick (X)

(ADDRESS) Atlanta, Mo.

Filed July 20, 1914 J. M. Halliburton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 15th, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 20, 1914, to July 15, 1914, that I last saw him alive on July 15, 1914, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:
Arteriosclerotic Valvular disease of the heart
92A
(Duration) 4 yrs. 0 mos. 0 ds.

Contributory 0
(SECONDARY) (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) Geo. Lyda, M. D.
July 18, 1914 (Address) Atlanta Mo.

*State the Disease Causing Death, or, in Death 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 McTabor DATE OF BURIAL July 16, 1914

UNDERTAKER F. M. Gooding ADDRESS Atlanta, Mo.

N. B.—Every item of information furnished is subject to examination and if found to be incorrect, the cause of death in particular, is very important.

VITAL RECORD

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....(NO.....)

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

St.....Ward)

(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)
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DATE OF BIRTH
.....(Month)....., /.....(Day)....., 191.....(Year)

AGE
.....yrs.....mos.....ds.
If LESS than 1 day,hrs. ormin.?

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

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

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.....m. The CAUSE OF DEATH was as follows:

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

*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. In the Where was disease contracted if not at place of death? Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain t...
SICILIANS should state...
TION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Macon

Township _____

or Village _____

or City Atlanta (NO. _____)

Registration District No. 526

File No. _____

Primary Registration District No. 4312

Registered No. _____

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

FULL NAME

Geo E Wolf

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH July 15, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____, 191____, and that death occurred, on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ min. If LESS than 1 day, _____ hrs. _____ min.

The CAUSE OF DEATH* was as follows:

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

Valvular Disease of the heart. mitral
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) _____

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

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) _____

Signature H. G. Lyda M. D. July 16, 1914 (Address) Atlanta Mo.

*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) _____

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 _____

(ADDRESS) _____

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

Filed July 20, 1914 J. M. Halliburton REGISTRAR

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Every item on this form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH. OCCUPATIONS very important. INFORMATION WILL UNFADING INK - THIS IS A PERMANENT RECORD.

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

23241

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.)