

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

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.

PLACE OF DEATH Portageville
 County Portage Registration District No. 607 File No. 42 23437
 Township Portage or Village Portageville Primary Registration District No. 4361 Registered No. _____
 City _____ (NO. _____ St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Thomas Jefferson Halden

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <input checked="" type="checkbox"/> <u>WIDOWED</u> (Write the word)
DATE OF BIRTH <u>don't know</u> 18 <u>64</u> (Month) (Day) (Year)		
AGE <u>about 50</u> yrs. <u>don't know</u> mos. <u>ds.</u>		If LESS than day, hrs. or min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Logging</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Contract work.</u>		
BIRTHPLACE (City or town, State or foreign country) <u>don't know</u>		
PARENTS	NAME OF FATHER <u>don't know</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>don't know</u>	
	MAIDEN NAME OF MOTHER <u>don't know</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>don't know</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 16, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 13th July, 1914, to July 16, 1914, that I last saw him alive on July 16, 1914, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Malaria

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

Contributory Cause of malaria
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) P. M. Mayfield M. D.
July 16, 1914 (Address) Portageville 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) P. M. Purcell
 (ADDRESS) Portageville Mo.

Filed July 16, 1914 J. M. N. Thompson REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Pellis Cemetery</u>	DATE OF BURIAL <u>7/17</u> , 191 <u>4</u>
UNDERTAKER <u>R. D. Young</u>	ADDRESS <u>Portageville Mo.</u>

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 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:

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

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. 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

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

PLACE OF DEATH

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

County New Madrid Registration District No. 607 File No. _____
 Township Portageville or Village _____ Primary Registration District No. 4361 Registered No. 42
 City _____ (NO. _____) (St. _____) (Ward _____)

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

FULL NAME Thomas Jefferson Holder

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH July 16, 1914
 (Month) (Day) (Year)

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

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.

AGE _____ yrs. _____ mos. _____
 if LESS than 1 day, _____ hrs. or _____ min. _____
Satisfactory Information Supplied

The CAUSE OF DEATH* was as follows:
Malaria
Satisfactory Information Supplied.

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

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) _____
Satisfactory Information Supplied.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) P. M. Mayfield M. D. July 14, 1914 (Address) Portageville

*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) Pleas. Purcell (ADDRESS) Portageville 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 Aug 14 1914 J. M. N. Thompson REGISTRAR

PLACE OF BURIAL OR REMOVAL St. Michael Cemetery DATE OF BURIAL 7-17-1914
 UNDERTAKER R. D. Young ADDRESS _____
Satisfactory Information Supplied.

N. B.—Every item of info written should be as fully supplied. AGK 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.

Revised United States Standard Certificate of Death

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

13431

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*, *peritonæum*, 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 septichaemia," "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.)