

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Clatsop
Township Wyaconda
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 194 File No. 28766
Primary Registration District No. 7152 Registered No. _____

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

FULL NAME Jacob Coffman

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married
WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH Dec 20, 1833
(Month) (Day) (Year)

AGE 81 yrs. 9 mos. 5 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) West Virginia

PARENTS
NAME OF FATHER Mike Coffman
BIRTHPLACE OF FATHER (City or town, State or foreign country) West Virginia
MAIDEN NAME OF MOTHER Elizabeth Hardsch
BIRTHPLACE OF MOTHER (City or town, State or foreign country) West Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H W Coffman
(ADDRESS) Wyaconda mo

Filed 1 1914 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 25, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 21, 1914, to Sept 25, 1914, that I last saw him alive on Sept 25, 1914, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:
Paralysis
131
82D

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

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A O Crumley M. D.
(Address) Wyaconda 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 Harmony Grove Cemetery DATE OF BURIAL Sept 27, 1914
UNDERTAKER Frank Smith ADDRESS Wyaconda

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

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

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

(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) _____
 IF LESS than 1 day, _____ hrs. or _____ min.?

AGE _____ yrs. _____ mos. _____ ds. _____ (Year) _____

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) _____

PARENTS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 1917 _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1917, to _____, 1917, that I last saw him _____ alive on _____, 1917, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

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

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

M. D. _____ (Address) _____, 1917 _____

*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 _____ in the _____
 Where was disease contracted _____ yrs. _____ mos. _____ ds. _____
 if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 1917 _____

UNDERTAKER _____ ADDRESS _____

Filed _____, 1917 _____ REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Clark
Township Wyaconda
Village _____
City _____

Registration District No. 194
Primary Registration District No. 7152

File No. _____
Registered No. _____

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

FULL NAME

Joseph Coffman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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

DATE OF BIRTH _____, 19____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 5:30 m.

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

The CAUSE OF DEATH* was as follows:
Paralysis caused from
Myocarditis Intermittent

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) _____

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

NAME OF FATHER _____

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

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

(Signed) _____ M. D.
19____ (Address) _____

MAIDEN NAME OF MOTHER _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____

Where was disease contracted If not at place of death? _____
Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 19____

Filed Oct 12 1914 _____ REGISTRAR

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

28766

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

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.)