

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

PLACE OF DEATH
County Howell
Township Howell
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 384 File No. 29140
Primary Registration District No. 5535 Registered No. 204

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

FULL NAME William F. Markham

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White ~~SINGLE~~ MARRIED Married
(If wife the word)

DATE OF BIRTH May 19, 1914
(Month) (Day) (Year)

AGE 53 yrs. 2 mos. 28 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) Tennessee

PARENTS NAME OF FATHER Wm. H. Markham
BIRTHPLACE OF FATHER Tennessee
MAIDEN NAME OF MOTHER Nancy Brwington
BIRTHPLACE OF MOTHER Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W.F. Markham
(ADDRESS) West Plains R.F.D

Filed 9-21 1914 H. O. P. A. Heinrich
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 17, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 5/26, 1914, to 8/17, 1914, that I last saw him alive on 8/14, 1914, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:
Mitral Incompetency;
9717
(Duration) 0 yrs. 5 mos. 17 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. E. Bess M. D.
8/17 1914 (Address) West Plains 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 or not at place of death? at Place of Res
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Dapping Springs DATE OF BURIAL Aug 18
UNDEXTAKER Markham ADDRESS West Plains

PLACE OF DEATH

County.....

Township.....

or

Village.....

or

City.....

Registration District No.

File No.

Primary Registration District No.

Registered No.

(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 (<i>Write the word</i>)
DATE OF BIRTH	(Month)	(Day)
AGE	(Year)	(Year)
 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)

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

(formant)

(ADDRESS)

191.....

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month)

....., 191..... (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 in

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory

(SECONDARY)

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

(Signed)

191.....

(Address)

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. 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

191.....

UNDERTAKER

ADDRESS

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 Howell
 Township Howell
 or
 Village _____
 or
 City _____ (NO _____ St _____ Ward _____)

Registration District No. 384 File No. _____
 Primary Registration District No. 5535 Registered No. 204

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

FULL NAME William F. Markham

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 Aug. 17, 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 alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

AGE 16
IF LESS than 1 day, hrs. or min. 2 yrs. mos. ds.

CAUSE OF DEATH* was as follows:
Mitral Incompetency
Heart Failure due to
Mitral Incompetency
(Duration) yrs. 5 mos. 17 ds.

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) _____

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds. _____
 (Signed) W. E. Row _____
9/17/14 (Address) West Plains, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

*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 _____

(Informant) _____

(ADDRESS) _____

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

FILE 9-21- 1914 W. E. Row REGISTRAR

UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

To be filled in by the informant. If the informant is a physician, he should state the cause of death in plain terms, such as "Heart Failure due to Mitral Incompetency". If the informant is a physician, he should state the cause of death in plain terms, such as "Heart Failure due to Mitral Incompetency".

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

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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