

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

PLACE OF DEATH

County Montgomery
Township Danville
or
Village New-Florence
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 593
Primary Registration District No. 5786 B

File No. 29837

Registered No. _____

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

FULL NAME Samuel Felix See

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH January 24, 1847
(Month) (Day) (Year)
AGE 67 yrs. 7 mos. 16 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

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

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on Sept 16, 1914, and that death occurred, on the date stated above, at noon m.

BIRTHPLACE (City or town, State or foreign country) Danville Mo
Randolph Co. Va.

The CAUSE OF DEATH* was as follows:
Heart failure he was not sick attended to business up to time of death of

PARENTS
NAME OF FATHER Jacob See
BIRTHPLACE OF FATHER (City or town, State or foreign country) Randolph Co. W. Va.
MAIDEN NAME OF MOTHER Rachel Morrison
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

200A (Duration) ____ yrs. ____ mos. ____ ds.
I was called after death and the above diagnosis
Contributory is presumptive
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Kalmeyer
(ADDRESS) Glasgow Mo

(Signed) F. P. Wyatt M. D.
9/18, 1914 (Address) New Florence

*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 _____

Filed Sept. 18, 1914, B. F. Holcombe
REGISTRAR

PLACE OF BURIAL OR REMOVAL New Florence Cemetery DATE OF BURIAL Sept 18, 1914
UNDERTAKER C. M. Wilson ADDRESS New Florence

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.

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, 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, 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.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

County Montgomery
Township Sauville
or
Village
or
City

Registration District No. 593 File No.
Primary Registration District No. 578613 Registered No.

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

FULL NAME Samuel Felix Lee

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 1 (Month) 1 (Day) 191 (Year)

AGE 1 yrs. 0 mos. 0 ds. IF LESS than 1 yrs. 0 mos. 0 ds. or 0 hrs. 0 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 Oct 27 1914 B. F. Holcombe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. 16, 1914
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from 1914, to 1914, that I last saw alive on 1914, and that death occurred, on 1914 date stated above, at m.

The CAUSE OF DEATH* was as follows: Head Failure
He says he was called after Mother's death and presumed (duration) of weak heart but does not know.

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

(Signed) 9/18/14 (Address) New Florence 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

UNDERTAKER ADDRESS

SUPPLEMENTARY Satisfactory Information Supplied

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

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