

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 Stoddard
County Stoddard
Township Twelve Registration District No. 839 File No. 31198
Village Charter Oak or Charter Oak Primary Registration District No. 6100 Registered No. 7
City _____ (NO. _____) St.: _____ Ward _____

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

FULL NAME Comodore Green

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____, 19 <u>01</u> (Month) (Day) (Year)		
AGE <u>13</u> 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) <u>Kentucky</u>		
PARENTS:	NAME OF FATHER <u>Wesley Green</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>	
	MAIDEN NAME OF MOTHER <u>Jane Medkiff</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>	

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 29, 1904
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* was as follows:
Heart failure
38
71 B (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____ (Duration) ____ mos. ____ ds.
(Signed) B. H. Harris M. D.
_____, 1904 (Address) Canonville 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) Calvin Waderfield
(ADDRESS) Charter Oak

PLACE OF BURIAL OR REMOVAL Charter Oak
UNDERTAKER John Parish
DATE OF BURIAL 8-30-1904
ADDRESS Storehouse
Mo

Filed 8-3-1904 J. W. Brough REGISTRAR

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, meningis, 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," "Uræmia," "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.)

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

PLACE OF DEATH

County

Robertson
Elk

Township

or

Village

or

City

Registration District No.

839

File No.

Primary Registration District No.

6100

Registered No.

61

FULL NAME

Comodore Green

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

M

COLOR OR RACE

W.

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

Aug 29 1914
(Month) (Day) (Year)

DATE OF BIRTH

901
(Month) (Day) (Year)

AGE

13 yrs. - mos. - ds.
If LESS than 1 day, hrs. or min.

I HEREBY CERTIFY, that I attended deceased from [redacted] 1914, that I last saw [redacted] live on [redacted] 1914, and that death occurred, on the date stated above, at [redacted].

The CAUSE OF DEATH* was as follows:

Heart failure

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)
Kentucky

(Duration) yrs. mos. ds.

NAME OF FATHER

Darius Green

Contributory

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

BIRTHPLACE OF FATHER

(City or town, State or foreign country)
Kentucky

(Signed) R. H. Harry M. D.
Aug 29 1914 (Address) Canton, Mo.

MAIDEN NAME OF MOTHER

Jane Medbiff

*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)
Ky.

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)

Calvin Kaufeld

Where was disease contracted If not at place of death?

(ADDRESS)

Charter Oak Mo.

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

Seheston Mo.

DATE OF BURIAL

8-30 1914

Filed

Sept 22 1914
H. J. Hurst M.D.
REGISTRAR

UNDERTAKER

John Paris

ADDRESS

Morhouse Mo.

AUG 1914

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the 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]

31198

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 septicæmia," "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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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Hodgdon
Township Twelve
Village _____
City _____ (NO. _____) St. _____ Ward _____

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

Registration District No. 839 File No. _____
Primary Registration District No. 6100 Registered No. A 61

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

FULL NAME Comodore Isner

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH		
SEX <u>M</u>	COLOR OF FACE <u>A</u>	MARRIAGE STATUS SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OR DIVORCED <input type="checkbox"/> (Write the word)		DATE OF DEATH <u>Aug 29</u> , 19 <u>14</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>Sept 4</u> , 19 <u>04</u> (Month) (Day) (Year)		AGE <u>9</u> yrs <u>11</u> mos <u>25</u> days		I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ on _____, 191____, and that death occurred, on the date stated above, _____ m.		
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		If LESS than 1 day, _____ hrs _____ or _____ min		The CAUSE OF DEATH* was as follows: <u>Heart Failure due to Angina</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u>		BIRTHPLACE OF FATHER <u>Kentucky</u>		Contributory (SECONDARY) <u>Melvin Fran</u> (Duration) _____ yrs _____ mos _____ ds.		
PARENTS	NAME OF FATHER <u>Wesley Isner</u>		NAME OF MOTHER <u>Elizabeth Midkiff</u>		SIGNED BY <u>B. H. Morris</u> M. D. <u>Aug 29</u> , 191 <u>4</u> (Address) <u>Casslon Mo</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Kentucky</u>		BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER <u>Elizabeth Midkiff</u>		BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Kentucky</u>		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) <u>Wesley Isner</u> (ADDRESS) <u>Casslon Mo</u>				Where was disease contracted If not at place of death? _____ Former or usual residence _____		
Filed <u>Sept 22</u> , 191 <u>4</u> <u>New J Aux</u>		REGISTRAR		PLACE OF BURIAL OR REMOVAL <u>Satisfactory Information Supplied</u>		
Original file, date <u>Sept. 1914</u>		All information called for must be written on this Supplementary Certificate.		DATE OF BURIAL _____ 191____ ADDRESS _____		

Revised United States Standard Certificate of Death

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