

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

PLACE OF DEATH  
County Greene  
Township Murray  
or  
Village  
or  
City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 323 File No. 38616  
Primary Registration District No. 5448 Registered No. 8

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

FULL NAME No Name

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Nov 28, 1914  
(Month) (Day) (Year)

AGE 8 yrs. 1 mos. 12 ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work X

(b) General nature of industry, business, or establishment in which employed (or employer) X

BIRTHPLACE (City or town, State or foreign country) Willard Mo

PARENTS  
NAME OF FATHER John Young  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Denmo  
MAIDEN NAME OF MOTHER Sarah Cunningham  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) J. B. Young  
(ADDRESS) Willard Mo R-3

Filed Dec 20, 1914 C. J. Pike REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 10, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 28, 1914 to Nov 28, 1914, that I last saw him alive on Nov 28, 1914, and that death occurred, on the date stated above, at 1570 m.

The CAUSE OF DEATH\* was as follows:  
myofur Citrus

1570  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 12 ds.

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

(Signed) C. J. Pike M. D.  
Dec 20, 1914 (Address) Willard

\*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 1 yrs. 12 mos. 12 ds. In the State 1 yrs. 12 mos. 12 ds.  
Where was disease contracted if not at place of death? at place  
Former or usual residence usual

PLACE OF BURIAL OR REMOVAL Clear Creek DATE OF BURIAL Dec 13, 1914

UNDERTAKER Ed fern ADDRESS Bonsalac

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, 8 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.)

PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Greene Registration District No. 323 File No. \_\_\_\_\_  
 or \_\_\_\_\_ Primary Registration District No. 5448 Registered No. 8  
 Township Murray St.: \_\_\_\_\_ Ward \_\_\_\_\_  
 or \_\_\_\_\_  
 City \_\_\_\_\_ (NO \_\_\_\_\_ St.: \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Baby Young

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Dec 10, 1914  
 (Month) (Day) (Year)

DATE OF BIRTH \_\_\_\_\_  
 (Month) (Day) (Year)

I, \_\_\_\_\_, hereby CERTIFY, that I attended deceased from \_\_\_\_\_, 1914 to \_\_\_\_\_, 1914, and that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 1914.

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

and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

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

morbus Cerebralis  
morbus Cerebelli

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

NAME OF FATHER \_\_\_\_\_

Contributory to lack of Forensic Care

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

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

MAIDEN NAME OF MOTHER \_\_\_\_\_

(Signed) C. J. Pike  
Dec 10, 1914 (Address) Willard Mo

BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

\*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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Informant) \_\_\_\_\_

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Clear Creek DATE OF BURIAL Dec 11, 1914

Filed Dec 31, 1914 C. J. Pike REGISTRAR

UNDERTAKER J. B. Redfean ADDRESS Bonadon

Original file, date \_\_\_\_\_ 1914, All information called for must be written on this Supplementary Certificate.

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