

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

39525

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

Registration District No. 547 File No. _____
Primary Registration District No. 5470 Registered No. 68

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

FULL NAME Harry Lee Roland

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)
DATE OF BIRTH Nov 1, 1914
(Month) (Day) (Year)
AGE 1 yrs. 20 mos. 20 ds. IF LESS than 1/2 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) Paris, Mo.

PARENTS
NAME OF FATHER James Roland
BIRTHPLACE OF FATHER Paris
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Pauline Cooper
BIRTHPLACE OF MOTHER Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Roland
(ADDRESS) Amundson

Filed 12/20/1914 J. S. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 20, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 13, 1914, to Dec 13, 1914, that I last saw her alive on Dec 13, 1914, and that death occurred, on the date stated above, at — m.
The CAUSE OF DEATH* was as follows:

Quinque
107H
(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) B. P. Davis M. D.
12/20/1914 (Address) Paris, 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 Fullbright DATE OF BURIAL 12/21/14

UNDERTAKER H. S. White & Co. ADDRESS Amundson

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, peritoneum*, 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.)

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE EXACTLY. PHYSICIANS SHOULD STATE DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

MISSOURI STATE BOARD OF HEALTH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

PLACE OF DEATH Mos
 County _____
 Township _____ or Village _____ or City _____ (No. _____ St. _____ Ward _____)
 Registration District No. 567 File No. _____
 Primary Registration District No. 5760 Registered No. 68

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

FULL NAME Nancy Lee Roland

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> OR DIVORCED <input type="checkbox"/> (<i>Write the word</i>) <u>S</u>	DATE OF DEATH <u>Dec 30</u> 191 <u>4</u> (Month) (Day) (Year)	
DATE OF BIRTH _____ (Month) _____ (Day) _____ (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 _____ m.	
AGE _____ yrs. _____ mos. _____ ds.			The CAUSE OF DEATH* was as follows: <u>Pneumonia</u> <u>Bronchitis</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			(Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) _____			Contributory _____ (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER _____		(Signed) <u>R O Aldridge</u> M.D. <u>12/30</u> 191 <u>4</u> (Address) <u>Quincy</u>	
	BIRTHPLACE OF FATHER (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.	
	MAIDEN NAME OF MOTHER _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (ADDRESS) _____			Where was disease contracted If not at place of death? _____ Former or usual residence _____	
Filed <u>12/30</u> 191 <u>4</u> <u>J. B. Quinn</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL _____	DATE OF BURIAL _____ 191____
			UNDERTAKER _____	ADDRESS _____

Satisfactory Information Supplied.
 SUPPLEMENTARY INFORMATION SUPPLIED.

Revised United States Standard Certificate of Death

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

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