

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
County St. Louis
Township _____ or Village _____ or City Maplewood (NO. 2604 Marshall St., _____ Ward)
Registration District No. 786 File No. 40008
Primary Registration District No. 4469 Registered No. 60
FULL NAME: Donald Lewis Rice [If death occurred in a hospital or institution, give its NAME instead of street and number].

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> <small>(Write the word)</small>	DATE OF DEATH <u>12-5</u> , 191 <u>4</u> <small>(Month) (Day) (Year)</small>		
DATE OF BIRTH <u>June 27</u> , 19 <u>06</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>12-2</u> , 191 <u>4</u> , to <u>12-5</u> , 191 <u>4</u> , that I last saw him alive on <u>12-4</u> , 191 <u>4</u> , and that death occurred, on the date stated above, at <u>99</u> m. The CAUSE OF DEATH* was as follows: <u>Typhoid</u>		
AGE <u>12</u> yrs. <u>5</u> mos. <u>8</u> ds.	IF LESS than 1 day, ___ hrs. or ___ min.?		<u>130</u> <small>(Duration) 2 yrs. ___ mos. ___ ds.</small>		
OCCUPATION (a) Trade, profession, or particular kind of work <u>at school</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory <small>(SECONDARY)</small> <small>(Duration) ___ yrs. ___ mos. ___ ds.</small>		
BIRTHPLACE? <small>(City or town, State or foreign country)</small> <u>St. Louis, Mo.</u>			(Signed) <u>H. P. P. Cheney</u> M. D. <u>12-7</u> , 191 <u>4</u> (Address) <u>7291 Maplewood</u>		
PARENTS	NAME OF FATHER <u>William Rice</u>		*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 FATHER <small>(City or town, State or foreign country)</small> <u>Empfield, Ill.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.		
	MAIDEN NAME OF MOTHER <u>Margaret Sullivan</u>		Where was disease contracted If not at place of death? _____ Former or usual residence _____		
BIRTHPLACE OF MOTHER <small>(City or town, State or foreign country)</small> <u>Sandusky, Ohio</u>			PLACE OF BURIAL OR REMOVAL <u>Empfield, Ill.</u> DATE OF BURIAL <u>Dec 7</u> , 191 <u>4</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. J. Rice</u>			UNDER TAKER <u>Parker and Co Maplewood</u>		
(ADDRESS) <u>Maplewood, Mo.</u>			ADDRESS <u>Parker and Co Maplewood</u>		
Filed <u>12/17</u> , 191 <u>4</u> <u>W. J. Rice</u> 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*, *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.)

PLACE OF DEATH

County

St. Louis

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

Township

Registration District No.

786

File No.

or Village

Primary Registration District No.

4469
2604 Marshall

Registered No.

60

or City

FULL NAME

Daniel Lewis Rice

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH *12-5* 191*4*
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, 191____
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, and that I last saw him alive on _____, 191____.

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

and that death occurred, on the date stated above, at *90* m.

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

THE CAUSE OF DEATH* was as follows: *acute nephritis*

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

(Informant) _____

(ADDRESS) _____

Filed *12/7* 191*4*

REGISTRAR

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

(Signed) *12-7* 191*4* (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 _____

DEC 1914

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

Satisfactory Information Supplied.
SUPPLEMENTARY
Satisfactory Information Supplied.

HEREBY CERTIFY
COPY
12-7
1914
Satisfactory Information Supplied.

Revised United States Standard Certificate of Death

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

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