

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

PLACE OF DEATH

County Lafayette
Township Deblou
or
Village
or
City Quetico (No. _____)

Registration District No. 455
Primary Registration District No. 5621a

File No. 1559
Registered No. _____

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

FULL NAME Emmett Lissin

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 DEATH Jan 17, 1915
(Month) (Day) (Year)

DATE OF BIRTH 9 27 1837
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 15, 1915, to Jan 17, 1915, that I last saw him alive on Jan 15, 1915,

AGE 77 yrs. 3 mos. 20 ds. IF LESS than 1 day, ___ hrs. or ___ min.?

and that death occurred, on the date stated above, at 4A m.

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

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
829
829

BIRTHPLACE (City or town, State or foreign country) Virginia

(Duration) 2 yrs. 2 mos. 0 ds.

NAME OF FATHER John Lissin

Contributory (SECONDARY) X (Duration) 2 yrs. 2 mos. 0 ds.

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

(Signed) H. B. Miller M. D. (Address) Stuyvesant

MAIDEN NAME OF MOTHER Ant Ruv

*State the Disease Causing Death, or, in death 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) Virginia

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Chas. Lissin

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

(ADDRESS) Quetico Mo

Where was disease contracted if not at place of death?

Filed Jan 20 1915 H. B. Caplinger REGISTRAR

Former or usual residence.

PLACE OF BURIAL OR REMOVAL Republican Cemetery DATE OF BURIAL 1/18, 1915

UNDERTAKER W. H. Soden ADDRESS Stuyvesant

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, 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.)

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 CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Lafayette
Township Freedom
or Village
or City

Registration District No. 455 File No. _____

Primary Registration District No. 5621A Registered No. 1

FULL NAME Erastus Lisson (NO. _____) St. _____ Ward _____

[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 M.
(Write the word)

DATE OF DEATH Jan 17, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1915, to _____, 1915, that I last saw h _____ alive on _____, 1915, and that death occurred, on the date stated above, at _____.

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

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) _____

Cerebral hemorrhage causing paralysis which lasted for several months

BIRTHPLACE (City or town, State or foreign country) _____

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

NAME OF FATHER _____

(Signed) W. D. Higginsville M. D. 1-17-1915 (Address)

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

Where was disease contracted If not at place of death _____

(Informant) _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1915

Filed: Apr 10 1915 R. C. Caplinger REGISTRAR

UNDERTAKER _____ ADDRESS _____

Revised United States Standard Certificate of Death

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

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1551
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