

## 1 PLACE OF DEATH

County Buchanan

Township .....

or

Village .....

or

City St. Joseph,(No. Innsworth Hospital, St. Ward)MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHRegistration District No. 85File No. 47554Primary Registration District No. 1001Registered No. 291

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

2 FULL NAME Charles Martin Walters

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married  
(Write the word)6 DATE OF BIRTH. Feb 14 1869  
(Month) (Day) (Year)7 AGE 46 yrs 1 mos 3 ds. If LESS than 1 day.....hrs. or.....min.?8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE  
(City or town, State or foreign country) IllinoisPARENTS  
10 NAME OF FATHER Henry Walters  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Pennsylvania  
12 MAIDEN NAME OF MOTHER Susanna Blessing,  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pennsylvania14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) L. Walters  
(Address) Gravity, Iowa.15 Filed Mar 17 1915 W. E. Harrington  
Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 17 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, that I attended deceased from March 8 1915 to March 17 1915 that I last saw him alive on March 17 1915 and that death occurred, on the date stated above, at 9 a. m.The CAUSE OF DEATH\* was as follows:  
Myocarditis  
1213  
93A (Duration)..... yrs..... mos..... ds.CONTRIBUTORY (Secondary) Acute appendicitis  
(Signed) Chas. J. ... M. D.  
March 17 1915 (Address) Gravity, Iowa

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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? Gravity, IowaFormer or usual residence Gravity, Iowa19 PLACE OF BURIAL OR REMOVAL Shenandoah, Iowa DATE OF BURIAL March 18 191520 UNDERTAKER HEATON & GOLE UND. CO. ADDRESS 224 S. 8th St.  
By J. W. ...

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, Composer, 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.)

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

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

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

Registration District No. 85 File No. \_\_\_\_\_  
 Primary Registration District No. 1001 Registered No. 291

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

FULL NAME Charles Martin Walters

PERSONAL AND STATISTICAL PARTICULARS

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

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

AGE \_\_\_\_\_ 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) \_\_\_\_\_

PARENTS  
 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 May 24 1915 W E Harrington  
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3 / 17, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 191\_\_\_\_,  
 that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,  
 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
Myocarditis Acute  
78

Contributory (SECONDARY) Acute appendicitis  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) Charles G. Jones M. D.  
31/17 1915 (Address) 114 Francis

\*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 \_\_\_\_\_

SUPPLEMENTARY INFORMATION SUPPLIED

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