

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 Jasper
Township _____ Registration District No. 408 File No. 8896
or _____
Village _____ Primary Registration District No. 3020 Registered No. 34
or _____
City Leitchfield (NO. 1003 by name) St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jeremiah Alonzo Salzer

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED Divorced
(Write the word) Divorced
DATE OF BIRTH Oct 29 1855 (Month) (Day) (Year)
AGE 58 yrs. 4 mos. 17 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Invalid 14 yrs
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

BIRTHPLACE
(City or town, State or foreign country) Lexington, Ky

PARENTS
NAME OF FATHER John Salzer
BIRTHPLACE OF FATHER (City or town, State or foreign country) Leitchfield, Ky
MAIDEN NAME OF MOTHER Mary Ann Salzer
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Leitchfield, Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Allegiance H. Salzer
(ADDRESS) Leitchfield, Mo
Files Mo. 1915-10-29-103 REGISTRAR W. E. Seale

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jeremiah Alonzo Salzer 1915 (Month) March (Day) 15 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 9th, 1915, to Mar 15th, 1915, that I last saw him alive on Mar 13th, 1915, and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Paralysis with other
81: complications
820

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) G. O. Owen M. D. Mar 19th 1915 (Address) 1044 Cedar St

*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 Leitchfield, Mo

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Central Hill Cem. Leitchfield, Mo 1915
UNDERTAKER ADDRESS
W. E. Seale, Leitchfield, Mo

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____, 191____	(Day) _____, 191____
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) _____

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 _____, 191____

REGISTRAR

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

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.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____, 191____ (Day) _____, 191____ (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 _____.

The CAUSE OF DEATH* was as follows: _____

Contributory

(SECONDARY)

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

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.

_____ 191____ (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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

UNDERTAKER

ADDRESS

_____, 191____

PLACE OF DEATH

County

Jasper

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

Township

Registration District No.

408

File No.

Village

Primary Registration District No.

3020

Registered No.

324

City

NO.

ST.

Ward)

FULL NAME

Jemiah Alongo Salyer

[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

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF DEATH

M

W

Married

Satisfactory Information Supplied
Feb. 18, 1915
(Month) (Day) (Year)

DATE OF BIRTH

(Month) (Day) (Year)

AGE

If LESS than
1 day, hrs.
or mins.

I HEREBY CERTIFY, that I attended deceased from _____, 191____, _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ 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:

Paralysis with other complication
Hemiplegia Bulbar Paralysis
(Duration) 14 yrs. mos.

BIRTHPLACE

(City or town, State or foreign country)

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

L. Areas M. D.

(Address) 1044 Cedar St. Carthage

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)

*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. ds. In the State yrs. mos. ds.

Where was disease contracted? If not at place of death?

Former or usual residence

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filed

J. W. C. Salyer

REGISTRAR

UNDERTAKER

ADDRESS

Original file, date

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All information called for must be written on this Supplementary Certificate.

N. B.—Every item of information should be carefully supplied. CAUSE should be stated. EXACT TIME, DATE, AND PLACE OF DEATH should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION, if any, should be stated.

SUPPLEMENTARY INFORMATION Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

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

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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 "Asthemia," "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.)