N. B. Payne

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

PLACE OF DEATH

County: Lafayette

Township: ____ or Village: ____ or City: Lexington (No. 126 North 11 St.; 2 Ward)

Registration District No.: 461 — File No.: 11 9109

Primary Registration District No.: 3024 — Registered No.: ____

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

FULL NAME William Stapleton Jr.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH: June 17, 1914 (Month) (Day) (Year)

AGE: 0 yrs. 7 mos. 26 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Kinkead Ill.

PARENTS
- NAME OF FATHER: William Stapleton
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky.
- MAIDEN NAME OF MOTHER: Lillie Stapleton
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Stapleton Sr

(ADDRESS) Lexington Mo.

Filed March 4 1915. J. L. Cole. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb 13, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 4, 1915, to Feb 12, 1915, that I last saw him alive on Feb 13, 1915, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

9
Meningitis
PA

(Duration) 1 yrs. ____ mos. 3 ds.

Contributory (Secondary) Secondary TB (Certain)

(Duration) ____ yrs. ____ mos. 3 ds.

(Signed) N. B. Payne M. D.

Feb 14, 1915 (Address) Lexington 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: Lexington Mo — DATE OF BURIAL: Feb 14 1915

UNDERTAKER: Ernest Foyert — ADDRESS: Lexington Mo

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, 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 *septichaemia*," "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 Lafayette

Township or Village or City Lexington (NO. ____ St.; ____ Ward)

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

Registration District No. 461 File No. ____

Primary Registration District No. 3024 Registered No. 11

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

FULL NAME William Stapleton Jr.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

SEX M. COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH ____ (Month) ____ (Day) 1 ____ (Year)

Satisfactory Information Supplied.

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) ____

Satisfactory Information Supplied.

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) ____

Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____

(ADDRESS) ____

Filed April 30 1915 J. L. Cope REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 13, 1915 (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.

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:

Meningitis (not Epidemic)
Teething.

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(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Pertussis

(Duration) ____ yrs. ____ mos. 31 ds.

(Signed) N. B. Pearson M.D.

3-14 1915 (Address) Lexington

*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 ____

Satisfactory Information Supplied.

PLACE OF BURIAL OR REMOVAL ____ DATE OF BURIAL ____ 191__

UNDERTAKER ____ ADDRESS ____

Original file, date MAR - 1915 19__ All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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