

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.

WRITE PLAINLY, WITH UNFADING INK

PLACE OF DEATH

County Camden
 Township Jackson
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

11815

Registration District No. 119

File No. _____

Primary Registration District No. 5721

Registered No. _____

FULL NAME

Vergil L. Blankenship

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Apr 4, 1890
 (Month) (Day) (Year)

AGE 42 yrs. 14 mos. 14 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

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

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

NAME OF FATHER Daniel Blankenship

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

MAIDEN NAME OF MOTHER Sarah Starks

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jani Blankenship

(ADDRESS) Montreal Mo

Filed Apr 18, 1915 W J Clarke

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr 18, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 13, 1915, to Apr 18, 1915, that I last saw him alive on an Apr 18, 1915, and that death occurred, on the date stated above, at 11 P m. The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia

108

92

(Duration) ____ s. ____ mos. ____ ds.

Contributory

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

(Signed) W J Clarke M. D. Apr 19, 1915 (Address) _____

*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 Freedom Cem DATE OF BURIAL Apr 19, 1915

UNDERTAKER _____ ADDRESS _____

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.)

N. B.—Every item of information should be carefully supplied. CAUSE should be stated EXACTLY. 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

County Campbell **REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.**

Township Jackson Registration District No. 119 File No. _____
or _____
Village _____ Primary Registration District No. 5171 Registered No. _____
or _____
City _____ (NO. _____ St. _____ Ward _____)

FULL NAME Virgil D. Blankenship

[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>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u>	DATE OF DEATH <u>Apr. 18</u> , 191 <u>5</u> (Month) (Day) (Year)	
DATE OF BIRTH _____, _____, 191____ (Month) (Day) (Year)			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. The CAUSE OF DEATH* was as follows: <u>Supplied</u>	
AGE ____ yrs. ____ mos. ____ days If LESS than 1 day, ____ hrs. ____ min.				
OCCUPATION (a) Trade, profession, or particular kind of work <u>Supplied</u> (b) General nature of industrial business, or establishment in which employed (or employer) <u>Supplied</u>			_____, _____, _____ (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) _____ M. D. _____, 191____ (Address) _____ *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 _____	
BIRTHPLACE (City or town, State or foreign country) <u>Supplied</u>				
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 <u>Apr 18</u> , 191 <u>5</u> <u>W J Clarke</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL <u>Freedom Cem</u> DATE OF BURIAL <u>4/19</u>, 191<u>5</u> UNDERTAKER <u>Mattie Caster</u> ADDRESS _____	

Revised United States Standard Certificate of Death

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

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