

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

1 PLACE OF DEATH

County St. Charles

Township _____
or

Village _____
or

City St. Charles

Registration District No. 257

File No. 13849

Primary Registration District No. 3036

Registered No. 58

(NO 416 Morgan St. _____ Ward)

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

2 FULL NAME David King

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE MARRIED WIDOWED OR DIVORCED single
(If write the word)

6 DATE OF BIRTH About 1870
(Month) (Day) (Year)

7 AGE About 45 yrs. mos. ds. 1 day, hrs. or min.?

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

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

10 NAME OF FATHER Andrew King

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

12 MAIDEN NAME OF MOTHER Annie Cook

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maurice Forsett

(Address) Wellsville Mo.

15 Filed April 27, 1915 Thomas H. Bonstetter
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 26th 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 25th 1915 to April 26th 1915 that I last saw him alive on April 26th 1915 and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH was as follows:

Acute Indigestion
1200
1180

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) _____

(Duration) yrs. mos. 1 ds.

(Signed) F. J. Jackson M. D.

427 1915 (Address) St. Charles Mo

*State the Disease Causing Death, or, in deaths 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?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Wellsville Mo DATE OF BURIAL April 27 1915

20 UNDERTAKER H. Hallinger ADDRESS St. Charles Mo

Information is carefully supplied that it may be printed in plain text.

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 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

St Charles

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

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N. B.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full terms, so that it may be classified. Exact statement of OCCUPATION is very important.

Township _____ Registration District No. _____ File No. _____

Village _____ Primary Registration District No. *3036* Registered No. *58*

City *St Charles* (NO. *416 Morgan* St., Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME *David King*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX *M* COLOR OF RACE *B* SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *S*

DATE OF DEATH _____, 191____ (Month) _____ (Day) _____ (Year)

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

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

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

The CAUSE OF DEATH* was as follows:
Acute Indigestion
Enteritis and Gastritis

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 *Apr 27* 191____ *St Charles* _____ REGISTRAR

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

(Signed) *John Jackson* M. D. *4127* (Address) *St Charles, 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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.
Satisfactory Information Supplied.

APR 26 191____
1042

Original file, date. *APR - 1915* 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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