

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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 Vernon  
Township \_\_\_\_\_ or Village \_\_\_\_\_ or City Schell City (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 877 File No. 18107  
Primary Registration District No. 4530 Registered No. 9

FULL NAME No name: Premature birth (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<br><u>Male</u>   | COLOR OR RACE<br><u>White</u>   | SINGLE<br>MARRIED <u>Single</u><br>WIDOWED<br>OR DIVORCED<br>(Write the word)  | DATE OF DEATH<br><u>May 12</u> , 19 <u>15</u><br>(Month) (Day) (Year)   |  |
| DATE OF BIRTH<br><u>May 12</u> , 19 <u>15</u><br>(Month) (Day) (Year)  |   | AGE<br>_____ yrs. _____ mos. _____ ds.   | I HEREBY CERTIFY, that I attended deceased from <u>May 12</u> , 19 <u>15</u> , to <u>May 12</u> , 19 <u>15</u> , that I last saw him alive on <u>May 12</u> , 19 <u>15</u> , and that death occurred, on the date stated above, at <u>11:30 p.m.</u> and that death occurred, on the date stated above, at <u>11:30 p.m.</u><br>The CAUSE OF DEATH* was as follows:<br><u>Inanition</u> |  |
| OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>At home</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) |   | 15<br>158<br>(Duration) _____ yrs. _____ mos. _____ ds.  |   |  |
| BIRTHPLACE<br>(City or town, State or foreign country) <u>Schell City</u>  |   | Contributory<br>(SECONDARY)<br>(Duration) _____ yrs. _____ mos. _____ ds.  |   |  |
| PARENTS  | NAME OF FATHER<br><u>Irvin Sterling Graham</u>  | (Signed) <u>H. C. Jarvis</u> M. D.<br><u>May 14</u> , 19 <u>15</u> (Address) <u>Schell City</u>  |   |  |
|  | BIRTHPLACE OF FATHER<br>(City or town, State or foreign country) <u>Nebraska Mo</u>   | * State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.                                 |   |  |
|  | MAIDEN NAME OF MOTHER<br><u>Mattie Johnson</u>  | LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. |   |  |
|  | BIRTHPLACE OF MOTHER<br>(City or town, State or foreign country) <u>Henry Co. Mo.</u> | Where was disease contracted if not at place of death?<br>Former or usual residence _____  |   |  |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>J. A. Graham</u><br>(ADDRESS) <u>Schell City Mo.</u>   |   | PLACE OF BURIAL OR REMOVAL<br><u>Schell City</u><br>DATE OF BURIAL<br><u>May 13</u> , 19 <u>15</u>   |   |  |
| Filed <u>May 14</u> , 19 <u>15</u> , <u>H. C. Jarvis</u><br>REGISTRAR  |   | UNDERTAKER<br><u>L. D. White</u><br>ADDRESS<br><u>Schell City</u>  |   |  |

# 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*, *Sar-*

*coma*, 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.)



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1 PLACE OF DEATH

County

*Nemmon*

Township

Village

City

2 FULL NAME

*Inf. (Graham)*

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

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

Registration District No.

*877*

File No.

Primary Registration District No.

*4530*

Registered No.

*9*

St. Ward

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

*M*

4 COLOR OR RACE

*W*

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

*1*

16 DATE OF DEATH

*May 12 1915*  
(Month) (Day) (Year)

6 DATE OF BIRTH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from Satisfactory Information Supplied.

7 AGE

If LESS than 1 day.....hrs. or.....min.?

that I last saw h..... alive on..... 191..... and that death occurred, on the date stated above, at *11:30 p.m.*

8 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:.....

*Inunction  
absence of sufficient vitality  
to sustain ~~heart~~*

9 BIRTHPLACE

(City or town, State or foreign country)

CONTRIBUTORY

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

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(Signed) *No. C. Jarvis* M. D.  
*May 14 1915* (Address) *Schell City Mo.*

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

Where was disease contracted if not at place of death?

Former or usual residence.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Filed *May 14 1915* *No. C. Jarvis* Registrar

Original file, date *May 15 1915*

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

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

151  
Satisfactory Information Supplied.

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