

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 Adair
Township Polk
or
Village _____
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 874
Primary Registration District No. 5003

File No. 18165

Registered No. _____

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

FULL NAME

Victor R. Spriggs

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE Single MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Feb. 19, 1905
(Month) (Day) (Year)

DATE OF DEATH June 24, 1915
(Month) (Day) (Year)

AGE 10 yrs. 4 mos. 16 ds. If LESS than 1 day, _____ hrs. or _____ min.?

I HEREBY CERTIFY, that I attended deceased from June 24, 1915 to June 24, 1915, that I last saw alive on after death, and that death occurred, on the date stated above, at 3 P. 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:
Struck
183

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

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

NAME OF FATHER Earl Spriggs

Contributory None
(SECONDARY)

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

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. B. Farrington M. D.

MAIDEN NAME OF MOTHER Louise Stinson

(Address) June 24, 1915 _____

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

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) L. A. Pollock

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) Greentop mo.

Where was disease contracted if not at place of death? _____

Filed June 25, 1915 L. B. Farrington REGISTRAR

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Refuge DATE OF BURIAL June 25, 1915

UNDERTAKER David Wilson ADDRESS Kirkville 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.

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

City _____ (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 _____

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

AGE _____ yrs. _____ mos. _____ ds. IF LESS than _____ 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) _____

MEDICAL CERTIFICATE OF DEATH

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

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.

The CAUSE OF DEATH* was as follows:

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)

PARENTS

CONTRIBUTORY _____ (Signed) _____ (Address) _____, 191____ M. D.

_____, 191____ (Duration) _____ yrs. _____ mos. _____ ds.

_____, 191____ (Duration) _____ yrs. _____ mos. _____ ds.

*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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

Filed _____, 191____ REGISTRAR _____

WITH UNFADING INK IS A PERMANENT RECORD

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

1 PLACE OF DEATH
County Adair
Township Balk
or
Village
or
City

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

Registration District No. 804 File No.
Primary Registration District No. 0013 Registered No.

2 FULL NAME Victor R. Spriggs (NO. 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 WIDOW OR DIVORCED (Write the word) Single
6 DATE OF BIRTH (Month) (Day) (Year) 1
7 AGE (yrs. mos. ds.) If LESS than 1 day (hrs. or min.?)

16 DATE OF DEATH (Month) (Day) (Year) June, 24, 1915
17 I HEREBY CERTIFY, that I attended deceased from (Date) 191 to (Date) 191, that I saw him (Duration) (yrs. mos. ds.) 191, and that death occurred, on the (Date) stated above, at (Address) m. The CAUSE OF DEATH* was as follows:

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

drowned
accidental
164

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

(Duration) (yrs. mos. ds.) none

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

CONTRIBUTORY (Secondary) (Duration) (yrs. mos. ds.)
(Signed) F B Farrington M.D.
June 24, 1915 (Address) Green Top Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)

*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 (Duration) (yrs. mos. ds.) In the State (yrs. mos. ds.)
Where was disease contracted if not at place of death?
Former or usual residence

15 Filed June 24, 1915 F B Farrington Registrar

19 PLACE OF BURIAL OR REMOVAL Refugee DATE OF BURIAL June 25, 1915
20 UNDERTAKER Davis & Pull ADDRESS Refugee

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*; *Broncho-pneumonia* ("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 inter-current) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *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.)