

PLACE OF DEATH

County Dallas
 Township Jasper
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 244 File No. 1 18634
 Primary Registration District No. 0338 Registered No. 244

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

FULL NAME Verma Nicols

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>S.</u> (Write the word)
DATE OF BIRTH <u>Jan 10, 1915</u> (Month) (Day) (Year)		
AGE <u>20</u> yrs. <u>20</u> mos. <u>20</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		

BIRTHPLACE (City or town, State or foreign country) <u>Dallas, Co. Mo.</u>	
PARENTS	NAME OF FATHER <u>W. A. Nicols</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>
	MAIDEN NAME OF MOTHER <u>_____</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>unk.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Nicols
 (ADDRESS) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 30, 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.

The CAUSE OF DEATH* was as follows:

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

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

(Signed) W. A. Nicols 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 _____

PLACE OF BURIAL OR REMOVAL Morgan Cemetery DATE OF BURIAL Jan 31, 1915
 UNDERTAKER Fred Johnson ADDRESS Cemetery and

Filed 6-10 1915 _____ REGISTRAR

PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO.

St.:

Ward):

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)	(Day), 19
AGE	(Month)	(Day), 19
	IF LESS than	
	i day, hrs.	191
	or min.?	191
 yrs. mos. ds.	

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

, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)

(Day), 19

(Year)

I HEREBY CERTIFY, that I attended deceased from

that I last saw h alive on , 191, to , 191

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

, 191 (Address)

M. D.

* 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, RECENT RESIDENTS)

At place of death, yrs. mos. ds. in the

Where was disease contracted yrs. mos. ds.

if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

WRITING WITH UNFADING INK - THIS IS A PERMANENT RECORD

PHYSICIANS should state EXACTLY, PHYSICIAN'S should state EXACTLY, PHYSICIAN'S should state EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

1 PLACE OF DEATH
County Dallas
Township Jasper
or
Village
or
City

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

CERTIFICATE OF DEATH
Registration District No. 244 File No. 1
Primary Registration District No. 5338 Registered No. 1
St. _____ Ward _____
If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Verna Kicks

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) S

16 DATE OF DEATH Jan 30 1915
(Month) (Day) (Year)

6 DATE OF BIRTH _____ 191____
(Month) (Day) (Year)

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

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

The CAUSE OF DEATH* was as follows:
Unknown

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

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

PARENTS
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) _____ M. D.
_____ 191____ (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) Cohery 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 _____ 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 _____ 191____ Registrar _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL _____ 191____
20 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*, *Composer*, *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), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "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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