

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

1 PLACE OF DEATH

County St. Louis
Township Cruise
or
Village
or
City

Registration District No. 684
Primary Registration District No. 5912

File No. 19723
Registered No. 23

2 FULL NAME William Chapple

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH June 13 1823
(Month) (Day) (Year)

7 AGE 92 yrs. 2 mos. 2 ds. If LESS than 1 day.....hrs. or.....min.?

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

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

10 NAME OF FATHER Dont Know

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

12 MAIDEN NAME OF MOTHER Dont Know

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Geo. W. Chapple
(Address) Bowling Green Mo

15 Filed 6/15th 1915 W. B. Summers Registrar

3 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15th 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 7th 1915 to June 15th 1915 that I last saw him alive on June 10th 1915 and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:
92A Paralysis
92D
97
(Duration)..... yrs..... mos. ✓ da.

CONTRIBUTORY (Secondary) (Duration)..... yrs..... mos..... da.

(Signed) W. Ziesley M. D. 675 1915 (Address) Bowling Green 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..... da. In the State..... yrs..... mos..... da.

Where was disease contracted if not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Troy Kansas DATE OF BURIAL June 18th 1915

20 UNDERTAKER Wmsley & Bankhead ADDRESS Bowling Green Mo

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, 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.)

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PLACE OF DEATH
 COUNTY Tyler REGISTRATION DISTRICT NO. 684 FILE NO. _____
 TOWNSHIP _____ OR _____
 VILLAGE _____ OR _____ PRIMARY REGISTRATION DISTRICT NO. 5912 REGISTERED NO. 23
 CITY _____ (NO. _____) ST. _____ WARD _____

2 FULL NAME William Phopple

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

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) W
 6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
 7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?
 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) _____
 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (Address) _____
 15 Filed 6/15 1915 W. J. Summers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____ (Month) June _____ (Day) 15 1915 (Year)
 17 I HEREBY CERTIFY, that I attended deceased from _____ to _____ 1915
 Satisfactory information supplied.
 that I last saw him _____ alive on _____ 1915
 and that death occurred, on the date stated above, at _____5:30 P. m.
 The CAUSE OF DEATH* was as follows:
Paralysis
Hemiplegic of right side. Arteriosclerosis
the result of atherosclerotic condition
arteries (Duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) G. H. Zinsley M. D.
6/15 1915 (Address) Bonding Green, 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 _____
 19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 1915
 20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION SUPPLIED.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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19723
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.)