

PLACE OF DEATH

County CassTownship Dayton

or

Village _____

or

City _____ (NO. _____ St. _____ Ward _____)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

24238
2A228Registration District No. 161

File No. _____

Primary Registration District No. 5226Registered No. 4

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

FULL NAME Armstrong (Infant)

PERSONAL AND STATISTICAL PARTICULARS

SEX

boy

COLOR OR RACE

whiteSINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)boy

DATE OF BIRTH

Aug 1, 1915
(Month) (Day) (Year)

AGE

____ yrs. ____ mos. 2 ds.If LESS than
1 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) _____

BIRTHPLACE

(City or town, State or foreign country)

Dayton Pop, Cass Co Mo

PARENTS

NAME OF FATHER

Chas. C. Armstrong

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Henry Co. Mo

MAIDEN NAME OF MOTHER

Margaret Blake

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Benton Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. C. Armstrong

(ADDRESS)

London City Mo R#

Filed

Aug 4, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Aug 3, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

Aug 1, 1915, to Aug 3, 1915,that I last saw him alive on Aug 3, 1915,and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

meningitis.119B79F

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

Contributory

(SECONDARY)

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

(Signed)

Rev C S Dodd

M. D.

Aug 4, 1915(Address) Dayton 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

Austin Mo

DATE OF BURIAL

Aug 4, 1915

UNDERTAKER

Kauffman

ADDRESS

London City 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.

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 "*Asithenia*," "*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.)

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

1 PLACE OF DEATH

County

Township

or

Village

or

City

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

Registration District No.

Primary Registration District No.

(NO.

St.

Ward)

File No.

Registered No.

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

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)

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 Aug 4, 1915

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, that I attended deceased from

that I last saw him on

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

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

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

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Original file, date AUG - 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]

24232

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