

## PLACE OF DEATH

County

*Perry*

Township

*Bois-Brule*

or

Village

City

(NO.   Registration District No. *1128*File No. *25487*Primary Registration District No. *5879-A* Registered No. *11*St.  Ward

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

FULL NAME *Chester Ge. Luck.*MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

## PERSONAL AND STATISTICAL PARTICULARS

SEX <i>Male</i>	COLOR OR RACE <i>White</i>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <i>Single</i>
DATE OF BIRTH <i>Jan. 6<sup>th</sup></i> , 1913 (Month) (Day) (Year)		
AGE <i>2</i> yrs. <i>7</i> mos. <i>15</i> ds. If LESS than 1 day, _____ hrs. or _____ min.?		

## OCCUPATION

(a) Trade, profession, or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *✓*

## BIRTHPLACE

(City or town,

State or foreign country) *Belgium Mo.*

PARENTS	NAMES OF FATHER <i>August Ge Luck.</i>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <i>Belgium Mo.</i>
	MAIDEN NAME OF MOTHER <i>Julia Tucker.</i>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <i>Belgium Mo.</i>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *August Ge Luck*(ADDRESS) *Belgium Mo*Filed *Aug 21*, 1915*C. H. Moore*

REGISTRAR

 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

*Aug 21<sup>st</sup>*, 1915  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from *Aug 8<sup>th</sup>*, 1915, to *Aug 24*, 1915, that I last saw him alive on *Aug 11<sup>th</sup>*, 1915, and that death occurred, on the date stated above, at *3 a. m.*

The CAUSE OF DEATH\* was as follows:

*Spont. Constriction of Brain*  
*38*  
*87A*(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. *12* ds.Contributory  
(SECONDARY)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *A. Brown.* M. D.191\_\_\_\_ (Address) *Belgium 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

DATE OF BURIAL

*Belgium, Mo* *Aug 23*, 1915

UNDERTAKER

ADDRESS

*Alvin Stachurs* *Belgium Mo.*

ONLY, 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.

# 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*, *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.)



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

Mean of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

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

Township Bois Brule Registration District No. 1178 File No. \_\_\_\_\_

Village \_\_\_\_\_ Primary Registration District No. 589-a Registered No. 11

City \_\_\_\_\_ (NO. \_\_\_\_\_) (Ward \_\_\_\_\_) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** Ellvens Ge Luck,

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>
6 DATE OF BIRTH <u>Satisfactory</u> (Month) _____ (Day) _____ (Year) _____		
7 AGE _____ yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. _____ 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) _____	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 21 1915  
(Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

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

The CAUSE OF DEATH\* was as follows: Supplied  
Congestion of Brain  
caused by malarial fever. (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. A. Brown M. D.  
8-21 1915 (Address) Bellevue

\*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 \_\_\_\_\_ 191\_\_\_\_

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

15 Filed Dec. 22, 1915 Charley Moore Registrar

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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*Tuberculosis of lungs, meninges, peritonæum, 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.)

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