

## 1 PLACE OF DEATH

County

*Scott*

Township

*Sylvania*

Village

City

(No. \_\_\_\_\_)

St.; \_\_\_\_\_

Ward) \_\_\_\_\_

## 2 FULL NAME

*Henry Slickard*

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

## STANDARD CERTIFICATE OF DEATH

State of

*MISSOURI*

Registered No.

*76597*

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*M*

4 COLOR OR RACE

*W*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (If state the word)

*S*

6 DATE OF BIRTH

*Feb 10, 1895*

(Month) (Day) (Year)

7 AGE

*10 yrs. 4 mos. 3 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

(State or country)

*MO*

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

*MO*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

*MO*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(Address) \_\_\_\_\_

15

Filed \_\_\_\_\_, 191\_\_\_\_\_

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*July 14, 1915*

(Month) (Day) (Year)

17 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:

*Algie Malaria?**38*

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

Contributory (SECONDARY) \_\_\_\_\_

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

(Signed) *H S Stowers*, M. D.\_\_\_\_\_, 191\_\_\_\_ (Address) *Oran*

\* 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

# 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 "Asthenia," "Anaemia" (merely sympto-

matic), "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, haemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyaemia, septicaemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

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 Scott  
Township Sylvania or Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
Registration District No. 820 File No. 26597  
Primary Registration District No. 6069 Registered No. 111

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

FULL NAME Henry Slinkard

**PERSONAL AND STATISTICAL PARTICULARS** | **MEDICAL CERTIFICATE OF DEATH**

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single  
(#write the word)

DATE OF DEATH 7/11, 1915  
(Month) (Day) (Year)

DATE OF BIRTH 2/10, 1905  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 7/11, 1915, to 7/14, 1915, that I last saw him alive on 7/14, 1915, and that death occurred, on the date stated above, at 6 P. m.

AGE 10 yrs. 5 mos. 3 ds.  
IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

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

Acute Malaria  
38  
04

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

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

NAME OF FATHER W. J. Slinkard

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) H. S. Winters M. D.

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

(Address) Oran Mo

MAIDEN NAME OF MOTHER Mary Wilfirth

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Earlie Slinkard  
(ADDRESS) Oran Mo

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

Filed 8/11 1915 REGISTRAR [Signature]

PLACE OF BURIAL OR REMOVAL Fair View Mo DATE OF BURIAL 7/15 1915  
UNDERTAKER Emory D. Hickey ADDRESS Oran Mo

# Revised United States Standard Certificate of Death

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

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