

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

*Laclede*

Township

*Gassonade*

Registration District No.

*45-3*

File No.

*28007*

Village

Primary Registration District No.

*5619*

Registered No.

City (NO. St. Ward)

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

FULL NAME

*Josiah A. C. Hatham*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

*Male*

COLOR OR RACE

*white*

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH

*Sept 24, 1915*  
(Month) (Day) (Year)

DATE OF BIRTH

*March 10, 1829*  
(Month) (Day) (Year)

AGE

*86 yrs. 6 mos. 14 ds.*

IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

I HEREBY CERTIFY, that I attended deceased from *Sept 14, 1915*, to *Sept 24, 1915*; that I last saw him alive on *Sept 23, 1915*; and that death occurred, on the date stated above, at \_\_\_ m.

The CAUSE OF DEATH\* was as follows:

*Chronic Bright's Disease*

*131*  
*170*  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory

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

(Signed)

*G. D. Hartley* M. D.  
*Oct 10, 1915* (Address) *Nebo 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

*C. Hatham Cemetery*

*Sept 25, 1915*

UNDERTAKER

ADDRESS

*E. Albert Kinble*

*Nebo Mo*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Robert C. Hatham*

(ADDRESS)

*Nebo Mo.*

Filed

*Sept 25, 1915*

*G. D. Hartley*

REGISTRAR

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

**PLACE OF DEATH**

County \_\_\_\_\_

Township \_\_\_\_\_ Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_

or Village \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

or City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a 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) _____, 191____, to _____, 191____	(Day) _____, 191____ (Year)
AGE	_____ yrs. _____ mos. _____ 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)		

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH** \_\_\_\_\_ (Month) \_\_\_\_\_, 191\_\_\_\_ (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:

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

**NAME OF FATHER**  
(City or town, State or foreign country)

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

**MAIDEN NAME OF MOTHER**  
(City or town, State or foreign country)

**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

**Contributory**  
(SECONDARY)

(Signed) \_\_\_\_\_, 191\_\_\_\_ (Address) \_\_\_\_\_ M. D.

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

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

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

**UNDERTAKER** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH  
 County Laclede  
 Township Gasconade  
 or  
 Village  
 or  
 City (NO. St. Ward)

Registration District No. 453 File No. ....  
 Primary Registration District No. 5619 Registered No. ....

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

2 FULL NAME Cosiah A. Chatham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

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) Robert Chatham (Address) Trbo Mo.

15 Filed Sept. 25 1915 G. D. Hartley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) Sept. 24 1915

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:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. 191 (Address)

\*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 191

20 UNDERTAKER ADDRESS

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

Satisfactory Information Supplied

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, 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 "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "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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