

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 Jackson
Township Jasper or Village Carrollton or City Carrollton (NO. _____ St. _____ Ward _____)
Registration District No. 407 File No. 30853
Primary Registration District No. 4241 Registered No. 56

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

FULL NAME Otto Wade

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb 26, 1915
(Month) (Day) (Year)

AGE 8 yrs. 8 mos. 20 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) Pittsburg Kansas

PARENTS
NAME OF FATHER J. B. Wade
BIRTHPLACE OF FATHER (City or town, State or foreign country) Henry Co Mo
MAIDEN NAME OF MOTHER Bertha Griffith
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Linn Co Kansas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Wade
(ADDRESS) Carrollton, Mo

Filed Oct. 20, 1915 J. P. Barry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 19, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 15, 1915, 1915, to Oct 19, 1915, 1915, that I last saw him alive on Oct 19, 1915, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis 1913
(Duration) ___ yrs. ___ mos. 15 ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) F. M. O'Kelley M. D.
Oct 20, 1915 (Address) Carrollton 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 Carrollton, Mo DATE OF BURIAL Oct 20, 1915
UNDERTAKER Webb City Ind. Co. ADDRESS Webb City, 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*, *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), 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 *septicæmia*," "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.)

CERTIFICATE OF DEATH

1 PLACE OF DEATH
Jasper
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. *407* File No. _____

Primary Registration District No. *4241* Registered No. *56*

City _____ NO. _____ St. _____ Ward _____

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

2 FULL NAME *Otto Wade*

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) *1* (Year) _____

7 AGE _____ yrs. _____ mos. _____ min. ? 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 *Oct. 20* 1915 *J. R. Barry* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct. 19* 191*5*
(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: *Cerebro-spinal Meningitis (unable to qualify) J. R. Barry*
61 (Duration) _____ yrs. _____ mos. *15* ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) *Oct 20* 191*5* (Address) *Casterville 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. _____ 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.

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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," "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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