

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 Callaway  
Township Cleveland Registration District No. 1111 File No. 32995  
or Stephens Primary Registration District No. 5-160 Registered No.  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

FULL NAME Henry Martin

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May (Month) 3<sup>rd</sup> (Day) 1911 (Year)

AGE 4 yrs. 6 mos. X ds. If LESS than 1 day, X hrs. or X min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work X  
(b) General nature of industry, business, or establishment in which employed (or employer) X

BIRTHPLACE (City or town, State or foreign country) Callaway, Missouri  
Henry Martin

PARENTS  
NAME OF FATHER Joseph H. Martin  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Henry County, Mo  
MAIDEN NAME OF MOTHER Stella Young  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Henry County, Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. Nicholas  
(ADDRESS) Stephens, Mo

Filed Nov 8 1915 B. H. Stephens REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. (Month) 3 (Day) 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 2, 1915, to Nov 3, 1916, that I last saw him alive on Nov 3, 1916, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH\* was as follows:  
Rheumatic Cough

Contributory (Duration) X yrs. X mos. 2 ds.

(Signed) A. J. Cox M. D.  
1916 (Address) Stephens, 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 Cape Chapel Cemetery DATE OF BURIAL Nov 3 1916  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**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**

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

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH..... (Month) ....., 191..... (Day) ....., 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from 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:

**CONTRIBUTORY**  
 (SECONDARY)..... (Duration)..... yrs..... mos..... ds.  
 (Signed)..... (Address)..... M. D. ....  
 \*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. State..... in the usual residence..... yrs..... mos..... ds.  
 Where was disease contracted if not at place of death?  
 Former or usual residence.....

**PARENTS**

NAME OF FATHER..... (City or town, State or foreign country)  
 BIRTHPLACE OF FATHER.....  
 MAIDEN NAME OF MOTHER..... (City or town, State or foreign country)  
 BIRTHPLACE OF MOTHER.....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)..... (ADDRESS)..... DATE OF BURIAL OR REMOVAL..... DATE OF BURIAL..... 191.....

UNDERTAKER..... ADDRESS.....

Filed..... 191..... REGISTRAR.....

## 1 PLACE OF DEATH

County

Township

or

Village

or

City

NO.

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

Registration District No.

Primary Registration District No.

File No.

Registered No.

St. Ward

[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

(Month) (Day) 1 (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)10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(City or town, State or foreign country)12 MAIDEN NAME  
OF MOTHER13 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

1915

Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) 1915

17 I HEREBY CERTIFY, that I attended deceased from

1915 to 1915

that I last saw h. alive on 1915

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

The CAUSE OF DEATH\* was as follows:

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

1915 (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

1915

20 UNDERTAKER

ADDRESS

Original file, date 1915, 19

All information called for must be written on this Supplementary Certificate.

WRITE PLAINLY WITH UNFADING INK IN THIS PERMANENT RECORD

MARGIN RESERVE FOR FINDING

V. S. NO. 2.

N. B.—Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Satisfactory Information supplied

# Revised United States Standard Certificate of Death.

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

32995

**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), 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 septichaemia," "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.)