

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 Dallas
Township Grant or Louisburg Mo. Registration District No. 242 File No. 857
Village Louisburg Mo. Primary Registration District No. 5335 Registered No. 11
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Louis A. Greene

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>✓</u>
DATE OF BIRTH <u>11 28 1882</u> (Month) (Day) (Year)		
AGE <u>83 yrs. 1 mos. 16 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Minister of Gospel</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Tenn.</u>		
PARENTS	NAME OF FATHER <u>William Green</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Unknown</u>	
	MAIDEN NAME OF MOTHER <u>Unknown</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Unknown</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
12-30 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 12-30, 1916, to 1-4, 1916, that I last saw him alive on 1-4, 1916, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:
Emoplegia

(Duration) 66 yrs. 6 mos.

Contributory (SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. S. Johnson M. D.
1-5, 1916 (Address) Louisburg 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. B. Rice
(ADDRESS) Louisburg Mo
Filed 1-9, 1916 W. S. Johnson
REGISTRAR

PLACE OF BURIAL OR REMOVAL
Credgington Cem. DATE OF BURIAL Jan-5 1916
UNDERTAKER D. A. Lindsey ADDRESS Louisburg Mo

PLACE OF DEATH

**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** _____

DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

AGE _____ yrs., _____ mos., _____ ds. **IF LESS than 1 day,** _____ hrs., or _____ min.?

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

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) _____

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____, 191____ (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:

_____ yrs., _____ mos., _____ ds.
(Duration)

_____ yrs., _____ mos., _____ ds.
(Duration)

Contributory
(SECONDARY)

(Signed) _____, 191____ (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 _____ 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** _____

WRITE IN PLAIN INK ON THIS SIDE OF THE CARD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. A PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AT RECORD

SIN

N. B.—Every item of information should be generally supplied. AGE should be stated EXACTLY. PHYSICIANS, when CAUSE OF DEATH is 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

1 PLACE OF DEATH

County Dallas
 Township Gant
 or
 Village
 or
 City (NO. St. Ward)

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

Registration District No. 242 File No.
 Primary Registration District No. 5335 Registered No. 11

2 FULL NAME Louis A. Greul

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 (Write the word) Single

6 DATE OF BIRTH (Month) (Day) 1 (Year)

7 AGE 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 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 1/8 1916 W. E. Gannon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191 (Year) 11/4/16

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191, that I last saw him/her 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) M. D. (Address) 191

*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 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

Original file, date Jan 16 1916 All information called for must be written on this Supplementary Certificate.

Satisfactory information supplied. SUPPLEMENTARY CERTIFICATE Satisfactory information supplied.

Revised United States Standard Certificate of Death

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

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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*; *Broncho-pneumonia* ("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 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.)