

## 1 PLACE OF DEATH

County Green  
 Township Jackson  
 or  
 Village  
 or  
 City (NO. St. Ward)

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

Registration District No. 322 File No. 1158  
 Primary Registration District No. 5447 Registered No. 27

## 2 FULL NAME

Olin Wickers

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

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH <u>July 2 1887</u> (Month) (Day) (Year)		
7 AGE <u>28 yrs 5 mos 13 ds</u>		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Green Co. Mo.</u>		
PARENTS	10 NAME OF FATHER <u>John W. Wickers</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Brown</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ark</u>	

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Wickers  
 (Address) Stratford, Mo. R. 3.

## 15

Filed Jan 8 1915 S. M. Edwards  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Dec 14 1915  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from  
 ..... 191..... to..... 191.....  
 that I last saw him..... alive on..... 191.....  
 and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage  
24  
87-6

(Duration)..... yrs..... mos..... ds.

## CONTRIBUTORY

(Secondary)

(Signed) W. B. Loynd  
Dec 14 1915 (Address) Springfield

\*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  
Cedar Bluff DATE OF BURIAL  
Dec 15 1915

20 UNDERTAKER  
Beckwith ADDRESS  
Rich Green

# 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; a void

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 *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.)

PERMITS REQUIRED

WITH UNFAIR

PHYSICAL OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be properly classified. Ex. CAUSE OF DEATH in plain terms, so that it may be properly classified.

1 PLACE OF DEATH

County Brew  
Township Jackson  
or  
Village  
or  
City

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

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

Registration District No. 322 File No.  
Primary Registration District No. 5447 Registered No. 27  
No. St. Ward

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

2 FULL NAME Oliver Nickers

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE If LESS than 1 day, hrs. or min. yrs. mos. ds.

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 Jan 8 1915 M. P. Edwards Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191 (Year) Dec 14 5

17 I HEREBY CERTIFY, that I attended deceased from 191 to 191 that I saw him alive on 191 and that death occurred, on the date stated above, at m.

the CAUSE OF DEATH\* was as follows: Central Nucleomyg

CONTRIBUTORY (Secondary) Syphilis (Duration) 3 yrs. mos. ds. (Signed) W. J. Coyner, Coroner Dec 14 5 (Address) Springfield

\*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 UNDERTAKER ADDRESS

Original file, date Jan 8 1915, 19

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

SUPPLEMENTARY INFORMATION SUPPLIED

# Revised United States Standard Certificate of Death

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

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8511

*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.)