

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

1 PLACE OF DEATH
County Greene Registration District No. 5448 File No. 6172
Township Murray or Primary Registration District No. 223 Registered No.
Village or City (NO. St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Arthur C. Persing

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE married
MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH Nov 14 1842
(Month) (Day) (Year)

7 AGE 73 yrs. 2 mos. 21 ds. IF LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Flourished Mich

PARENTS

10 NAME OF FATHER Samuel Persing

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn.

12 MAIDEN NAME OF MOTHER Mary Prutzman

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 4 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 27 1916 to Feb 4 1916, that I last saw him alive on Feb 4 1916, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
108 Pneumonia

(Duration) 9 yrs. 9 mos. 9 ds.

CONTRIBUTORY (Secondary) (Duration) 9 yrs. 9 mos. 9 ds.

(Signed) C. J. Palk M. D.
Feb 5 1916 (Address) Willard

*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 25 yrs. 5 mos. 5 ds. In the State 50 yrs. 5 mos. 5 ds.

Where was disease contracted if not at place of death? at place

Former or usual residence Usae

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. C. Persing
(Address) Willard mo

15 Filed Feb 21 1916 C. J. Palk
Registrar

19 PLACE OF BURIAL OR REMOVAL Joice City DATE OF BURIAL Feb 6 1916
20 UNDERTAKER J. W. Klinger ADDRESS Springwood

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.

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1 PLACE OF DEATH

County Green
Township Murray
or
Village
or
City

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 323 File No.
Primary Registration District No. 5448 Registered No. ✓
St. Ward

2 FULL NAME

Abraham C. Persing

[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 OF RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED M.
(Write the word)

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

7 AGE
hrs. mos. yrs. 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 Feb 5 1916 R. J. Peter Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
Feb. 4 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from
to
that I last saw him alive on
and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. ds. 9

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.
(Signed) R. J. Peter
75 1916 (Address) Willard, 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

20 UNDERTAKER ADDRESS

SUPPLEMENTARY CERTIFICATE OF DEATH

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*, *Composer*, *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);

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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 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.)