

1916 - MISSOURI STATE BOARD OF HEALTH
 1885 - BUREAU OF VITAL STATISTICS
 30 - 2 - 21
 11 - 24
 665

PLACE OF DEATH
 County Pallas
 Township Waukegan
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

Registration District No. 665 File No. 74716
 Primary Registration District No. 5885 Registered No. 665

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

FULL NAME Frank L. Reed

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 2 21 1885
(Month) (Day) (Year)

AGE 30 yrs. 11 mos. 21 ds.
 IF LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Saline Co

NAME OF FATHER William Reed

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

MAIDEN NAME OF MOTHER Mary Hunt

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Cooper Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Hill
 (ADDRESS) Waukegan, Mo.

Filed Feb 15 1916 V. N. Smith
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 15, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 8, 1916, to Feb 15, 1916, that I last saw him alive on Feb 15, 1916, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:
Apoplexy following dis. to secondary hemorrhage

16 1/2 (Duration) 6 1/2 yrs. 3 mos. 3 days

Contributory gun shot wound of head
(SECONDARY)

(Duration) 7 yrs. 7 mos. 7 ds.

(Signed) C. L. Parkhurst, M. D.
Feb 15, 1916 (Address) Waukegan, 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 Berwyn, Mo. DATE OF BURIAL 2-16-1916

UNDERTAKER B. G. Voigt ADDRESS Waukegan, Mo.

PLACE OF DEATH

County.....
 Township.....
 or Village.....
 or City.....
 (NO. St.: Ward)

Registration District No.

Primary Registration District No.

File No.

Registered No.

[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)..... (Day)..... (Year).....
 AGE..... yrs..... mos..... ds. 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).....
 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

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

MEDICAL CERTIFICATE OF DEATH

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

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:

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

Contributory (SECONDARY)

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

(Signed)..... M. D.

191..... (Address).....

*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.....

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

PLACE OF DEATH
County Pettis
Township Houstonia
or
Village
or
City

Registration District No. 665 File No. 27Primary Registration District No. 5885 Registered No. 665

NO. St. Ward

[If death occurred in a
hospital or institution,
give its NAME instead
of street and number.]2 FULL NAME Frank L. Reed

PERSONAL AND STATISTICAL PARTICULARS

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

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

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 15 1916 W. J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 15 1916
(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

The CAUSE OF DEATH* was as follows:

Apoplexy due to
Secondary haemorrhage
(Probably suicidal shot)
Duration) yrs. mos. ds. 3 hrs

CONTRIBUTORY Gun shot wound of head
(Secondary)
Duration) yrs. mos. ds.

(Signed) W. J. Smith M. D.
Feb 15 1916 (Address) Houstonia

*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

Original file, date Feb 15 1916

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

ONLY, 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.

SUPPLEMENTARY

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*; *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 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.)