

PERMANENT RECORD

Information from this form 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 Phelps  
Township Blount  
or  
Village  
or  
City \_\_\_\_\_ (No.) \_\_\_\_\_

Registration District No. 676 File No. 7508  
Primary Registration District No. 5899 Registered No. 3  
St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Leslie Paul

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single  
DATE OF BIRTH Nov. 11, 1913  
(Month) (Day) (Year)  
AGE 2 yrs. 3 mos. 13 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?  
OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS

NAME OF FATHER Chas Paul  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.  
MAIDEN NAME OF MOTHER Loretta Morse  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Chas Paul

(ADDRESS) Newburg Mo

Filed 2/28 1916 B. B. Smith  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 24, 1916  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 2, 1915, to Feb. 24, 1916, that I last saw him alive on Feb 23, 1916, and that death occurred, on the date stated above, at 60 m.

The CAUSE OF DEATH\* was/as follows:  
Tetany  
Following 156 Burns & Operation  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) B. B. Smith M. D.  
2/25, 1916 (Address) Newburg 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 Stoach Cemetery DATE OF BURIAL 2/28, 1916

UNDERTAKER F Spadlog ADDRESS Newburg Mo

# 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); *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), 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.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. P.

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.

1 PLACE OF DEATH  
Philps  
Arlington

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

County Philps Registration District No. 676 File No. 7508  
 Township Arlington or Primary Registration District No. 5899 Registered No. \_\_\_\_\_  
 Village \_\_\_\_\_ or City (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2 FULL NAME Leslie Paul [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 FACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S  
 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 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 6/30 1916 B. L. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 24 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 \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:  
tetanus following Burns & operations  
Operation was for debridement of hands, caused from burn & contraction of fingers  
 CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) B. L. Smith M. D. 2-24, 1916 (Address) Newburg, 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 \_\_\_\_\_, 191\_\_\_\_  
 20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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

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**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.)

THIS IS A PERMANENT RECORD

N. B.—Any item of information should be carefully applied. 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**

1 PLACE OF DEATH  
 County Shelby REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW  
 Township Orbington Registration District No. 676 File No. ....  
 or Village ..... Primary Registration District No. 5899 Registered No. 3  
 or City ..... (NO. ....) St. .... Ward) !! If death occurred in a hospital or institution, give its NAME instead of street and number.

2 FULL NAME Leslie Paul

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S</u>	16 DATE OF DEATH <u>Feb - 24</u> 191 <u>6</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Satisfactory Information Supplied</u> (Month) (Day) 1 (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.	
7 AGE ..... yrs. Inf. .... mos. .... ds.		IF LESS than 1 day, .... hrs. or .... min.?	The CAUSE OF DEATH* was as follows: <u>slavery</u> <u>24</u> <u>Following fever &amp; operation</u> <u>Case was treated at Grand Hospital</u> <u>of this city. Could not find any</u> <u>cause from the diary of Dr. ...</u> <u>to ...</u> (Duration) yrs. .... mos. .... ds. (Signed) <u>W. B. Smith</u> M. D. <u>125</u> 191 <u>6</u> (Address) <u>W. B. Smith</u>	
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 <u>2/25</u> 191 <u>6</u> <u>W. B. Smith</u> Registrar			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 - 24, 1916 All information called for must be written on this Supplementary Certificate.

# Revised United States Standard Certificate of Death

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*Tuberculosis of lungs, meninges, peritonacum, 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.)