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

1 PLACE OF DEATH

County Jasper

Township or Village or City Carthage (NO. ..... St. ..... Ward)

Registration District No. 408 File No. 21552

Primary Registration District No. 3020 Registered No. 138

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

2 FULL NAME Neal Dow Walker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May (Month) 27 (Day) 1853 (Year)

7 AGE 63 yrs. ..... mos. 16 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer 13
(b) General nature of industry business or establishment in which employed (or employer) 13

9 BIRTHPLACE (City or town, State or foreign country) Kent

PARENTS

10 NAME OF FATHER Greenberry Walker

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

12 MAIDEN NAME OF MOTHER E. Beard

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kent

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Bush

(Address) Webb City

15 Filed June 14, 1916 W E Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 13 (Month) (June 13) (Day) 1916 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 6, 1916, to June 12, 1916, that I last saw him alive on June 12, 1916, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Uraemia following prostatectomy

Several years (Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) E J Burch M. D.

June 13, 1916 (Address) Carthage 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 Webb City - Cem

DATE OF BURIAL June 15, 1916

20 UNDERTAKER Webb City - Und Co

ADDRESS Webb City.

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; 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), *20 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 *septichaemia*," "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.)

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

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

Registration District No. 408 — File No. ____

Primary Registration District No. 3020 — Registered No. 138

1 PLACE OF DEATH

County: Jasper

Township or Village or City: Carthage (NO. ____, ____ St.; ____ Ward)

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

2 FULL NAME Neal Dow Walker

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) ____, 1____ (Year)

Satisfactory Information Supplied.

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): ____

Satisfactory Information Supplied.

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): ____

Satisfactory Information Supplied.

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) ____

Satisfactory Information Supplied.

15 Filed 6/14, 191 6 W E Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 13 (Month) (Day), 191 6 (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.

Satisfactory Information Supplied.

The CAUSE OF DEATH* was as follows:

Albuminuria following Scarlatina 120

Semilis, ____ (Duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis ____ (Duration) not known yrs. ____ mos. ____ ds.

(Signed) E J Burch M. D.

6/13, 191 6 (Address) Carthage 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 ____

Satisfactory Information Supplied.

19 PLACE OF BURIAL OR REMOVAL ____ DATE OF BURIAL ____, 191____

20 UNDERTAKER ____ ADDRESS ____

SUPPLEMENTARY

Original file, date JUN 1916, 19____

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

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. CAUSE OF DEATH in plain terms.

Revised United States Standard Certificate of Death

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

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21552