

WRITE PLAINLY, 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.

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

PLACE OF DEATH
County Platte ✓
Township Green or
Village or
City _____ NO. _____ St.: _____ Ward _____
Registration District No. 692 File No. 25424
Primary Registration District No. 5919B Registered No. _____

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

FULL NAME G. Marion McMillan

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
(If use the word)
DATE OF BIRTH March 4, 1904
(Month) (Day) (Year)
AGE 12 yrs. 4 mos. 11 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Had none other

BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS
NAME OF FATHER J. W. McMillan
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
MAIDEN NAME OF MOTHER Millie Clark
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. W. McMillan
(ADDRESS) Dearborn Mo
Filed July 6, 1916 REGISTRAR M. M. Moore

1 MEDICAL CERTIFICATE OF DEATH

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

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

The CAUSE OF DEATH* was as follows:
Drowning ✓

(Duration) Sudden mos. ✓ ds.

Contributory Crampe
(SECONDARY) (Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Jos. M. Halem, M. D.
7-18-1916 (Address) Dearborn, 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? Had none
Former or usual residence Dearborn Mo

PLACE OF BURIAL OR REMOVAL New Market Mo DATE OF BURIAL July 16, 1916
UNDERTAKER J. N. Rollins ADDRESS Dearborn Mo

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.

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

PLACE OF DEATH

County _____
 Township _____ or _____ File No. _____
 Village _____ or _____ Registered No. _____
 City _____ (No. _____) St. _____ Ward _____
 Registration District No. _____ Primary Registration District 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)	IF LESS than 1 day, _____ hrs or _____ min.?	
AGE _____ yrs. _____ mos. _____ ds.	that I last saw him _____ alive on _____, 191____, to _____, 191____	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____	and that death occurred, on the date stated above, at _____ m.	
BIRTHPLACE (City or town, State or foreign country) _____	The CAUSE OF DEATH was as follows: _____	
NAME OF FATHER _____	Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE OF FATHER (City or town, State or foreign country) _____	_____ (Duration) _____ yrs. _____ mos. _____ ds.	
MAIDEN NAME OF MOTHER _____	(Signed) _____ (Address) _____, 191____ (M. D.)	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____	* 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 _____		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year)

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:

Contributory
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ (Address) _____, 191____ (M. D.)

* 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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____ (ADDRESS) _____

Filed _____, 191____ REGISTRAR

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

N. B.—Every item of information should be definitely ascertained. 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.

PLACE OF DEATH
*Platte
Green*

County
Township
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. *692* File No.
Primary Registration District No. *59AB* Registered No.
St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *G. Marion McMillan*

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
Satisfactory information supplied.
(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 *July 6, 1916* Registrar *M. W. Mason*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
July 15, 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 191... to 191...
that I last saw h..... 191...
and that death occurred, on the date above, at m.
The CAUSE OF DEATH* was as follows:

Drowning accidental
169 (Duration) yrs. mos. ds.
sudden

CONTRIBUTORY (Secondary)
Cramps in water
(Duration) yrs. mos. ds.
(Signed) *7-18-16* (Address) *Dearborn 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
Ypsilville 191...

20 UNDERTAKER
M. H. Hallius ADDRESS *Dearborn Mo*

Original file, date *July 1916*

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

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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);

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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.)

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