

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

89

PLACE OF DEATH  
County Barry  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Purdy

Registration District No. 31 File No. \_\_\_\_\_  
Primary Registration District No. 4022 Registered No. 1  
St.: \_\_\_\_\_ Ward) \_\_\_\_\_

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

FULL NAME Charley Shankes

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single  
(Write the word)  
DATE OF BIRTH Jan 8 1917  
(Month) (Day) (Year)  
AGE 33 yrs. mos. 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) \_\_\_\_\_

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

PARENTS  
NAME OF FATHER unknown  
BIRTHPLACE OF FATHER (City or town, State or foreign country) unknown  
MAIDEN NAME OF MOTHER unknown  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) W. H. Worthington  
(ADDRESS) Purdy Mo.

Filed \_\_\_\_\_, 191\_\_\_\_ REGISTRAR \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 8 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 4, 1917, to Jan 8, 1917, that I last saw him alive on Jan 8, 1917,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH was as follows:  
Gastric Cancer  
466 (Duration) abt 2 yrs yrs. mos. ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. mos. ds.  
(Signed) W. H. Worthington M. D.  
Jan 9, 1917 (Address) Purdy 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 Purdy Mo. DATE OF BURIAL Jan 9 1917  
UNDERTAKER H. Raines ADDRESS Purdy Mo.

## PLACE OF DEATH

County.....  
 Township.....  
 or  
 Village.....  
 or  
 City.....

Registration District No. ....

File No. ....

Primary Registration District No. ....

Registered No. ....

(NO. ....)

St. ....

Ward) .....

(If death occur  
 hospital or in  
 give its NAME,  
 of street and num

## FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OR DIVORCED <i>(If file the word)</i>
DATE OF BIRTH	(Month) .....	(Day) .....
AGE	..... yrs. .... mos. .... ds.	(Year) .....
OCCUPATION	IF LESS than 1 day, .... hrs. or ..... min.?	

(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

## Revised United States Standard Certificate

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

## MEDICAL CERTIFICATE OF DEATH

## DATE OF DEATH

(Month) .....

(Day) .....

I HEREBY CERTIFY, that I attended deceased  
 ....., 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH\* was, as follows:

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

## Contributory

(SECONDARY)

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

(Signed) .....

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

\*State the Disease Causing Death, or, in deaths from Violent Causes  
 (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT  
 RESIDENTS)

At place of death..... yrs. .... mos. .... ds. State..... yrs. .... mos.  
 where was disease contracted  
 if not at place of death?  
 Former or usual residence.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

County Barry Registration District No. 31 File No. ....  
 Township or Village or City Proby Primary Registration District No. 4027 Registered No. 1  
 (NO. .... St. .... Ward)   
 2 FULL NAME Charles Shanks [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 OR RACE A 5 SINGLE MARRIED WIDOWED OR DIVORCED Single  
 (Write the word)  
 6 DATE OF BIRTH ..... 191.....  
 (Month) (Day) (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) .....  
 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 Jan 9 1917 A. J. Clarys  
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 8 191.....  
 (Month) (Day) (Year)  
 17 I HEREBY CERTIFY, that I attended deceased from ..... 191..... to ..... 191.....  
 that I last saw him ..... 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.  
 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 INFORMATION SUPPLIED

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN, if any, should be stated EXACTLY. OCCUPATION in very plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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), *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.)