

STATEMENT OF OCCUPATION IS VERY IMPORTANT.

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

PLACE OF DEATH
County: Jackson
Township: Law
or Village: Lawrence
or City: City Mo.

Registration District No. 399 File No. 1421
Primary Registration District No. 1002 Registered No. 240
(NO. 3031 Truett Mo. St. _____ Ward _____)

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

FULL NAME Raymond Patsy Retter

PERSONAL AND STATISTICAL PARTICULARS

SEX Mr COLOR OR RACE Mr SINGLE Married
MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Oct. 12th 1874
(Month) (Day) (Year)
AGE 42 yrs. 3 mos. 3 ds. If LESS than 1 day, _____ hrs. or _____ min.?

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

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

PARENTS
NAME OF FATHER John R Retter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana
MAIDEN NAME OF MOTHER Anna E Patsy
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. I. Miller
(ADDRESS) 1620 Linwood

Filed JAN 15 1917 1917
Thos. F. Miller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 14, 1917
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Nov 1-17, 1916, to 1-14, 1917, that I last saw him alive on 1-14, 1917, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:
Myocard Regurgitation

93 93
(Duration) 10 yrs. _____ mos. _____ ds.
Contributory my own inefficiency
(SECONDARY) (Duration) _____ yrs. 4 mos. _____ ds.
(Signed) W. P. Miller M. D.
1-15, 1917 (Address) 305 1/2

*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 Washington DATE OF BURIAL Jan 16, 1917
UNDERTAKER Geo J. Stewart Co ADDRESS 3317 1/2

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), 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.)

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F. M. B. B. B.
A. J. B. B. B.