

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

2245

1 PLACE OF DEATH

County Monroe Registration District No. 587 File No. ....  
Township Woodlawn or ..... Primary Registration District No. 1585 Registered No. 1  
Village ..... or ..... City ..... (NO. .... St. .... Ward) .....

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

2 FULL NAME William Heathman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH June 15 1873  
(Month) (Day) (Year)

7 AGE 44 yrs. x mos. y ds. If LESS than 1 day... hrs. or... min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Monroe Co Mo

PARENTS  
10 NAME OF FATHER Lepta Heathman  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo  
12 MAIDEN NAME OF MOTHER Sara Sanders  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) S. P. Pickett  
(Address) Madison, Mo.

15 Filed 1/16 1917 Tend, Wedding  
Registrar

2) MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 10 1917, to June 15 1917, that I last saw him alive on June 14 1917, and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH\* was as follows:  
Pneumonia

105  
92A  
c (Duration) yrs. mos. ds. 5

CONTRIBUTORY Choleraic Heart Disease  
(Secondary) (Duration) 3 yrs. mos. ds.

(Signed) J. D. ... M. D.  
June 16, 1917 (Address) St. Louis, 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 Robt. Grave Cemetery DATE OF BURIAL 1/16 1917

20 UNDERTAKER Fred A. Thompson ADDRESS Madison, Mo.

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.

WILL UNFADING INK—THIS IS A PERMANENT RECORD

# LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

### 1 PLACE OF DEATH

County .....  
 Township ..... File No. 117  
 or  
 Village ..... Primary Registration District No. .... Registered No. ....  
 or  
 City ..... (NO. ....) St. .... Ward) .....

If death occurs  
 hospital or  
 give its NAME  
 of street and

### 2 FULL NAME

#### PERSONAL AND STATISTICAL PARTICULARS

3 SEX .....  
 4 COLOR OR RACE .....  
 5 SINGLE  
 MARRIED  
 WIDOWED  
 OR DIVORCED  
 (Write the word)  
 6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 191..... (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) .....

#### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day) ..... 191.....  
 17 I HEREBY CERTIFY, that I attended deceased .....  
 that I last saw h..... alive on..... 191.....  
 and that death occurred, on the date stated, above, at .....  
 The CAUSE OF DEATH\* was as follows: suicide

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)  
 At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. ....  
 Where was disease contracted if not at place of death?  
 Former or usual residence .....  
 CONTRIBUTORY (Secondary) ..... yrs. .... mos. ....  
 (Signed) ..... (Duration) ..... yrs. .... mos. .... (Address) .....  
 \*State the Disease Causing Death, or in death from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL .....  
 20 UNDERTAKER ..... ADDRESS .....

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

1 PLACE OF DEATH  
 County Monroe  
 Township Woodlawn  
 or  
 Village

Registration District No. 587  
 Primary Registration District No. 5185

File No. \_\_\_\_\_  
 Registered No. 1

City \_\_\_\_\_ NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward) \_\_\_\_\_

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

2 FULL NAME William Heathman

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Jan 15 1917  
 (Month) (Day) (Year)

6 DATE OF BIRTH \_\_\_\_\_  
 (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.

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

The CAUSE OF DEATH\* was as follows:

8 OCCUPATION \_\_\_\_\_  
 Trade, profession, or particular kind of work

Lobar Pneumonia  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(b) General nature of industry business, or establishment in which employed (or employer)

CONTRIBUTORY Valvular Heart Disease  
 (Secondary) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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)

(Signed) J. B. Brannon M. D.  
 Jan 16, 1917 (Address) Duncan's Ridge

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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 \_\_\_\_\_

(Informant) \_\_\_\_\_  
 (Address) \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

15 Filed \_\_\_\_\_ 1917 Filed  
5-20-1117 Registrar

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

# 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);

*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 "Asthma," "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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