

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

5224

1 PLACE OF DEATH

County Dade
Township North
or
Village Arcola
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 240 File No. _____
Primary Registration District No. 5332 Registered No. _____

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

2 FULL NAME

Adam L. Calfee

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 April 17, 1851
(Month) (Day) (Year)
7 AGE 65 yrs. 9 mos. 28 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) Agricultural

9 BIRTHPLACE
(City or town, State or foreign country) Blue Field W. Va.

PARENTS
10 NAME OF FATHER Not known
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lela Calfee
(Address) Arcola Mo.

15 Filed Mar 10, 1917 A. Higgins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 15, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h..... alive on _____, 191____, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:
2 D Heart Failure
fell dead
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. Higgins M. D.
Mar 15, 1917 (Address) A. Higgins

*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 Hickory Grove Amory DATE OF BURIAL Feb 16, 1917

20 URBERTAKER Higgins ADDRESS Arcola Mo

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*, *peritoneum*, 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.)

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

1 PLACE OF DEATH

County Dade
 Township North
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

Registration District No. 240 File No. _____

Primary Registration District No. 5332 Registered No. _____

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

2 FULL NAME

Adam L. Calfee

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH
 (Month) _____ (Day) _____ 1 (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) _____

15 Filed Nov 10 1917 A Higgins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 15 1917
 (Month) _____ (Day) _____ (Year) _____

17 I HEREBY CERTIFY, that I attended deceased from _____ 1917 to _____ 1917, that I last saw him _____ alive on _____ 1917, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Heart Failure
full Dead. Paralysis
 (Duration) _____ mos. _____ ds.

CONTRIBUTORY (Secondary)
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) A Higgins M.D.
3-15-1917 (Address) Arcola, Mo.

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

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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 _____ 1917

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY INFORMATION

Original file, date FEB 1917, 19 _____

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]

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1225
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.)