

## 1 PLACE OF DEATH

County Hickory  
 or  
 Township Green  
 or  
 Village  
 or  
 City (NO. St. Ward)

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

Registration District No. 362 File No. 10107-2  
 Primary Registration District No. 5507 Registered No.

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

2 FULL NAME unnamed

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX ✓ 4 COLOR OR RACE ✓ 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)  
 6 DATE OF BIRTH Mar 5 1917  
 (Month) (Day) (Year)  
 7 AGE 15 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) Pittsburg mo.

PARENTS  
 10 NAME OF FATHER James M. Bigler  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) mo  
 12 MAIDEN NAME OF MOTHER Phesia Johnson  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Bigler  
 (Address) Pittsburg mo.

15 Filed April 10 1917 J. D. Wainkle  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 20 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..... m.

The CAUSE OF DEATH\* was as follows:

no attending physician  
200B (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

8 Signed J. D. Wainkle M. D.  
Mar 20 1917 (Address) Pittsburg 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 Antisch DATE OF BURIAL ✓ 191

20 UNDERTAKER Sam Martin ADDRESS Pittsburg 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, Composer, 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.)

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

1 PLACE OF DEATH  
 County St. Louis  
 Township Green  
 or  
 Village  
 City (NO. \_\_\_\_\_) \_\_\_\_\_

Registration District 362 File No. \_\_\_\_\_  
 Primary Registration District No. 5507 Registered No. \_\_\_\_\_  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

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

2 FULL NAME unmarried Bigler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE w 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)  
 6 DATE OF BIRTH Mar. 3, 1917  
 7 AGE 15 yrs. 15 mos. 15 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 (of employer) \_\_\_\_\_  
 9 BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_  
 10 NAME OF FATHER Marion Bigler  
 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) no info supplied  
 12 MAIDEN NAME OF MOTHER Elizabeth Johnson  
 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) ma

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 20, 1917  
 17 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:  
 \_\_\_\_\_  
 \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. 17 mos. 17 ds.  
 CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (Signed) J. D. Winkle M. D. June 25, 1917 (Address) Pittsburg 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 \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Marion Bigler (Address) Pittsburg mo.

15 Filed Oct 14 1917 J. D. Winkle Registrar

19 PLACE OF BURIAL OR REMOVAL Antioch DATE OF BURIAL Mar 21, 1917  
 20 UNDERTAKER Carroll Martin ADDRESS Pittsburg mo

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health  
Association)

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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 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 "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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