

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

PLACE OF DEATH
County Montrouay
Township Pilat Gravel
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 577 File No. 9 11376
Primary Registration District No. 5775 Registered No. _____

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

FULL NAME Latham Curtis

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>	DATE OF DEATH <u>2</u> <u>March</u> <u>30</u> , 191 <u>7</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>July 20</u> , 18 <u>47</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Mar 10</u> , 191 <u>7</u> , to <u>March 30</u> , 191 <u>7</u> , that I last saw h <u>im</u> alive on <u>March 30</u> , 191 <u>7</u> , and that death occurred, on the date stated above, at <u>A.P.</u>	
AGE <u>69</u> yrs. <u>8</u> mos. <u>10</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?	The CAUSE OF DEATH* was as follows: <u>Uremic Poison</u> <u>135B</u> <u>132B 170</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u>			(Duration) _____ yrs. _____ mos. <u>2</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Mansfield, Ohio</u>			Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>A. W. Nathan</u> M. D. <u>Mar 30</u> , 191 <u>7</u> (Address) <u>Delphos, Ohio</u>	
PARENTS	NAME OF FATHER <u>Mass Curtis</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Maine</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	MAIDEN NAME OF MOTHER <u>Do Not Know</u>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Do Not Know</u>		Where was disease contracted if not at place of death? Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>L Curtis</u> (ADDRESS) <u>Kanaan City Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Stacklan, Mo</u>	
Filed <u>Apr 1</u> , 191 <u>7</u> , <u>L. L. Latham</u> REGISTRAR			DATE OF BURIAL <u>Apr 3</u> , 191 <u>7</u>	
			ADDRESS <u>California</u>	

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*, *Sar-*

coma, 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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CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Monteau
Township Calat Grov
or
Village
or
City

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

Registration District No. 577 File No.
Primary Registration District No. 5775 Registered No. 9
St. Ward

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

2 FULL NAME Letau Curtis

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
If LESS than 1 day.....hrs. or.....min.?
.....yrs.....mos.....da.

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 1 1917 J. L. Latham Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 30 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:
maemie Parson
170
(Duration) yrs.....mos.....ds.

CONTRIBUTORY Chronic Cystitis
(Secondary)
(Duration) 2 yrs.....mos.....ds.
(Signed) K. W. Latham M. D.
Mar 30 1917 (Address) Latham

*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
B. H. Schutz

Original file, date Feb 17, 1917

All information called for must be written on this Supplementary Certificate.

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[Approved by U. S. Census and American Public Health
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