

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

1 PLACE OF DEATH
County Butler
Township _____
or
Village _____
or
City Poplar Bluff (NO. _____ St.: _____ Ward)

Registration District No. 89 File No. 13969
Primary Registration District No. 3007 Registered No. 109

2 FULL NAME Claud Lee Hest

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

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE Single
MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH April 16 1917
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
_____ yrs. _____ mos. 12 ds.

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

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

10 NAME OF FATHER Joseph Hest
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia
12 MAIDEN NAME OF MOTHER Dora Stovall
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Poplar Bluff Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph L. Hest
(Address) Poplar Bluff

15 Filed May 11, 1917
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 28 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 27, 1917, to Apr 27, 1917, that I last saw h. alive on Apr 17, 1917, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:
Blood poisoning -
1530
1530
36
(Duration) _____ yrs. _____ mos. 6 ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. M. Davidson M. D.
Apr 28, 1917 (Address) Poplar Bluff Mo.

*State the Disease Causing Death, or, in death 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 Black Creek DATE OF BURIAL Apr 29, 1917

20 UNDERTAKER None ADDRESS _____

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, 8 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.)

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 Butler
Township..... Registration District No. 89 File No.....
or
Village Poplar Bluff Primary Registration District No. 3007 Registered No. 107
City..... (INO.....) St..... Ward.....

2 FULL NAME Clara Lee Kent

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

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).....

16 DATE OF DEATH Apr 28 1917
(Month)..... (Day)..... (Year).....

17 I HEREBY CERTIFY, that I attended deceased from..... 191..... to..... 191.....
that death was due to..... 191.....
and that death occurred, on the date stated above, at..... m.
The CAUSE OF DEATH* was as follows:
Blood Tox, not diff-erently known, 7 month child. Skin became inflamed and large blisters formed breaking down into ulcers.
CONTRIBUTORY (Secondary)..... yrs..... mos..... ds.
(Stated)..... M. D.
Apr 28 1917 (Address) Poplar Bluff 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..... 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).....
(Address).....

15 Filed July 12 1917 Hate Ellis
Registrar

19 PLACE OF BURIAL OR REMOVAL..... DATE OF BURIAL..... 191.....
20 UNDERTAKER..... ADDRESS.....

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

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Tuberculosis of lunge, 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 "Asthemia," "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 of statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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