

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

1 PLACE OF DEATH

County Deer
Township Asaga
or
Village
or
City

Registration District No. 268 File No. 14308

Primary Registration District No. 5375 Registered No.

(NO. _____ St. _____ Ward)

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

2 FULL NAME unnamed infant child

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) 1
6 DATE OF BIRTH April 6 - 1917
(Month) (Day) (Year)
7 AGE _____ yrs. _____ mos. 2 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) Vogt Mo

PARENTS
10 NAME OF FATHER Lawrence L Baker
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Manfield Mo
12 MAIDEN NAME OF MOTHER Macy Baker
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dark Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) P. Q. Miner (Address) Vogt Mo

15 Filed May 8 1917 P. H. Conaway Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 8 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 6 o'clock 4-8-1917 to 7 o'clock 4-8-1917 that I last saw him alive on evening 4-7-1917 and that death occurred, on the date stated above, at early a.m.
The CAUSE OF DEATH* was as follows:

Strangulation or suffocation to the best of my knowledge.
(Duration) _____ yrs. _____ mos. 2 ds.

CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Mrs. P. Q. Miner 4-9-1917 (Address) Vogt 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 Home DATE OF BURIAL 4/9 1917
20 UNDERTAKER Home ADDRESS Vogt

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, 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 *Deer*
Township *Osage*
or
Village
or
City

Registration District No. *268* File No.
Primary Registration District No. *5375* Registered No.
(No) St. Ward

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

2 FULL NAME

Infant Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *S*

6 DATE OF BIRTH *Apr. 6th 1917*
(Month) (Day) (Year)

7 AGE *Satisfactory Information Supplied*
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) *Vogt Mo*

10 NAME OF FATHER *Lammie Baker*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Manchester Ohio*

12 MAIDEN NAME OF MOTHER *Ida Baker*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Osage Mo.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Apr 8 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 *2* m.

The CAUSE OF DEATH* was as follows:
Asphyxiation or suffocation to the best of my knowledge

(Duration) *177* yrs. *2* mos. *2* ds.

CONTRIBUTORY (Secondary) *177*
(Duration) yrs. mos. ds.

(Sign) *Mrs P. P. Munn midwife*
Apr 9 1917 (Address) *Vogt Mo*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *O. A. Mower*
(Address) *Vogt Mo*

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death... yrs... mo... ds. In the State... yrs... mos... ds.
Where was disease contracted if not at place of death?
Former or usual residence.

15 Filed *May 8 1917* *R. B. Bonaway*
Registrar

19 PLACE OF BURIAL OR REMOVAL *James Keys Cemetery* STATE OF BURIAL *Osage* 1917
20 UNDERTAKER ADDRESS

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, 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), 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.)