

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

1 PLACE OF DEATH

County Ozark Registration District No. 920 File No. 19463  
Township Jay Jasper or Primary Registration District No. 5858 Registered No. \_\_\_\_\_  
Village \_\_\_\_\_ or City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

2 FULL NAME

Elizah Friend

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Widower  
(Write the word)  
6 DATE OF BIRTH The month is unknown 1. 830  
(Month) (Day) (Year)

7 AGE 87 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Soldier of the 1860s

9 BIRTHPLACE (City or town, State or foreign country) Ark (Pennsylv)

PARENTS  
10 NAME OF FATHER James Friend  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio  
12 MAIDEN NAME OF MOTHER Jennie Hillwood  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Elisabeth Taber  
(Address) Callinsville, Ohio  
(Daughter of the deceased)

15 Filed May 18, 1917 Mary Robinson  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1917  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mo. Medical Aid in 1917, that I last saw him last illness and that death occurred, on the date stated above, at 730 m.

The CAUSE OF DEATH\* was as follows:  
General Complications  
Kidney and E. D. Dropsy  
was the last  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 96 ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Mo. Medical Aid M. D.  
in 1917 (Address) last illness

\*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, 37 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State, Must all his life yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence near Theodora, Mo.

19 PLACE OF BURIAL OR REMOVAL Friend Cemetery DATE OF BURIAL May 18, 1917

20 UNDERTAKER Wesley Sullivan ADDRESS Gainesville, Mo.

7 Item of information should be carefully supplied. \*AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# 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.)

CERTIFICATE OF DEATH

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

1 PLACE OF DEATH

County Wash Registration District No. 920 File No. \_\_\_\_\_  
Township Geyer or \_\_\_\_\_ Primary Registration District No. 5859 Registered No. \_\_\_\_\_  
Village \_\_\_\_\_ or \_\_\_\_\_ City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

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

2 FULL NAME

Elyah Freund

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>W</u>
6 DATE OF BIRTH (Month) _____ (Day) _____ 1 _____ (Year) _____		
7 AGE _____ 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, by establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country)		
PARENTS	10 NAME OF FATHER <u>W. D. Friend</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ohio</u>	
	12 MAIDEN NAME OF MOTHER <u>J. C. Billwood</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Maryland</u>	

Satisfactory information supplied.  
WRITING SUPPLEMENTARY INFORMATION

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
(Month) May 18 1917  
(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 \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:  
General Complication  
Kidney and Dropsy  
was the next Hart failure  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 96 ds.

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

(Signed) No. Medical M. D. \_\_\_\_\_ 1917 (Address) and in hospital

\*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 \_\_\_\_\_ 1917

20 UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Elizabeth Taber  
(Address) W. D. Friend  
1015 E. 12th St.  
St. Louis, Mo.

15 Filed May 18, 1917 Mary J. Johnson  
Registrar

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.

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**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*; *Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);

19463  
*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.)