

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

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 Jasper  
Township \_\_\_\_\_  
or \_\_\_\_\_  
Village \_\_\_\_\_  
or \_\_\_\_\_  
City Carthage

Registration District No. 408 File No. 25507  
Primary Registration District No. 3020 Registered No. 175  
(NO. Carthage Hospital St.: \_\_\_\_\_ Ward)  [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Adam Buck

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married  
WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Dec 4, 1862  
(Month) (Day) (Year)

AGE 54 yrs. 7 mos. 5 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.?

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

BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS  
NAME OF FATHER Wm Buck  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
MAIDEN NAME OF MOTHER Unknown  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Florence Buck  
(ADDRESS) Washington, D. C.

Filed July 10 1917 W Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 9, 1917  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 6, 1917, to July 9, 1917, that I last saw him alive on July 9, 1917, and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH\* was as follows:  
Acct. death due to Fracture of Base of skull

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

Contributory (SECONDARY)   
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) T. E. Baker M. D.  
7/9/17 1917 (Address) Carthage Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Carlton Ill DATE OF BURIAL July 11 1917

UNDERTAKER Quell Mnd Co. Carthage Mo. ADDRESS \_\_\_\_\_

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 OCCURRENCE in plain terms.

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

PLACE OF DEATH

County.....  
 Township..... Registration District No..... File No.....  
 or Village..... Primary Registration District No..... Registered No.....  
 or City.....(NO. ....) St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX..... COLOR OR RACE.....  
 SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)

DATE OF BIRTH.....(Month).....,.....(Day).....,.....(Year).....  
 AGE.....yrs.....mos.....ds.....  
 If LESS than 1 day,.....hrs. or.....min.?

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

BIRTHPLACE  
 (City or town, State or foreign country).....

NAME OF FATHER.....  
 BIRTHPLACE OF FATHER (City or town, State or foreign country).....  
 MAIDEN NAME OF MOTHER.....  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country).....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant).....  
 (ADDRESS).....

Filed....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH.....(Month).....,.....(Day).....,.....191.....(Year).....  
 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:

Contributory (SECONDARY)  
 (Signed)....., 191.....(Address)..... M. D.,  
 (Duration).....yrs.....mos.....ds.  
 (Duration).....yrs.....mos.....ds.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
 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.....

PLACE OF BURIAL OR REMOVAL..... DATE OF BURIAL....., 191.....  
 UNDERTAKER..... ADDRESS.....

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

Inadequate 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

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

1 PLACE OF DEATH  
County Jasper  
Township  
or  
Village  
or  
City Carthage (NO. .... St. .... Ward)

Registration District No. 408 File No. ....  
Primary Registration District No. 3050 Registered No. 175

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

2 FULL NAME Adam Luck

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH  
(Month) (Day) 1 (Year)

7 AGE  
If LESS than 1 day ..... hrs. or ..... min.?  
..... 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)

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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
(Month) July (Day) 9 191 (Year) 7

17 I HEREBY CERTIFY that I attended deceased from ..... 191 ..... to ..... 191 .....  
that I last saw her/alive on ..... 191 .....  
and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH\* was as follows:  
Heart Dist due to fracture of Bone of skull

(Duration) 172 yrs. mos. da.

CONTRIBUTORY (Secondary) Fell off of a Churn onto sidewalk of stone  
(Duration) yrs. mos. da.

(Signed) T. B. Baker M. D.  
9/7, 191 (Address) Carthage

\*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. da. In the State, yrs. mos. da.  
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 Sept. 7, 1917, C. B. Taylor  
Registrar

19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL ..... 191 .....

20 UNDERTAKER ..... ADDRESS .....

Original file, date July 10, 19 17

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

# 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 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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