

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

1 PLACE OF DEATH
County Greene
Township _____
or _____
Village _____
or _____
City Springfield (No. 228 N Main St. _____ Ward)

318
Registration District No. _____ File No. 28293
Primary Registration District No. 2001 Registered No. 499

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

2 FULL NAME Charles C. Davis

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Mar 9 1883
(Month) (Day) (Year)

7 AGE 33 yrs. 9 mos. 7 ds. If LESS than 1 day... hrs. or... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Acting as an employment agent
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) MO

PARENTS
10 NAME OF FATHER Chas. Davis
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Sarah E. Davis
13 BIRTHPLACE OF MOTHER Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Delia Russell
(Address) 1625 East Fairchild

15 AUG 16 1917 Filed _____ 1917 Registrar Chas. F. Jones

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 16 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Hemorrhage of lungs at 228 N Main St Springfield Mo
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____
(Signed) Chas. Faxon (Address) Springfield Mo
(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.
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 Springfield Mo DATE OF BURIAL Aug 17 1917
20 UNDERTAKER J. W. Higgins Co ADDRESS 424 East Com

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.)

1 PLACE OF DEATH

County Greene

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

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

Township _____

Registration District No. 318

File No. _____

Village _____

Primary Registration District No. 2001

Registered No. 499

City Springfield

(NO. _____) St. _____ Ward _____

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

FULL NAME Charles S. Lewis

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (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) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____

15 Filed Oct 6 1917 Registrar Edw. J. Fair

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16 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 _____ m.

The CAUSE OF DEATH* was as follows:
Macromorphosis of Lungs
Tuberculosis of Lungs
(Duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (Signed) E. J. Tabor M. D. (Address) _____ 1917

*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 _____ STATE OF BURIAL _____ 1917

20 UNDERTAKER _____ ADDRESS _____

Satisfactory Information Supplied

SUPPLEMENTARY

Satisfactory Information Supplied

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
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28293

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.)