

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

29270

1 PLACE OF DEATH
County Monroe
Township Marion
Village
City (NO. St. Ward)

Registration District No. 579 File No.
Primary Registration District No. 5776 Registered No.

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

2 FULL NAME John Baxter Todd

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH May 29 1915
(Month) (Day) (Year)

7 AGE 2 yrs. 3 mos. 11 ds.
If LESS than 1 day, hrs. or min.?

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) Monroe Co Mo

PARENTS
10 NAME OF FATHER Amos Todd
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Follie Rose
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mollie Sumpter
(Address) Madison Mo

15 Filed 9/11 1917
F. L. Walker Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug. 10th 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug. 10th 1917 to Aug. 10th 1917
that I last saw him alive on Aug. 10th 1917
and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion
1185
698 (Duration) yrs. mos. ds. ✓

CONTRIBUTORY (Secondary)
McRaeley (Signed) M. D.
Aug 12th 1917 (Address) Madison 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 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 Madison Mo DATE OF BURIAL 8/12 1917
20 UNDERTAKER Fred A. Thompson ADDRESS Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County
 Township
 or
 Village
 or
 City (NO.) (NO.) (NO.) (Ward)

Registration District No. File No.
 Primary Registration District No. Registered No.

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED. (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)			

MEDICAL CERTIFICATE OF DEATH

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

17 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
 The CAUSE OF DEATH* was as follows:

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)

PARENTS

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
 (Address)

CONTRIBUTORY
 (Secondary) yrs. mos. ds.
 (Signed) 191..... (Address) M. D.

*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
 DATE OF BURIAL 191.....

20 UNDERTAKER
 ADDRESS

1 PLACE OF DEATH

County Monroe
Township Manon
or
Village
or
City

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

Registration District No. 579
Primary Registration District No. 5776

File No.
Registered No.

(NO St. Ward)

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

2 FULL NAME

John Baxter Todd

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH 191.....
(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)

PARENTS
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 8-17 1917 W. W. Hubert
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 10 1917
(Month) (Day) (Year)

17 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:
Acute Indigestion
Auto Intoxication
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 10 of
(Duration) yrs. mos. ds.
(Signed) W. W. Hubert M. D.
Aug 10 1917 (Address)

*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 191.....

20 UNDERTAKER ADDRESS

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 it is especially in industrial employments, where 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), *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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