

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty CarterTownship Johnson

Village _____

City _____ (NO. _____)

Registration District No. 145Primary Registration District No. 5208File No. 8 31274Registered No. 71

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

FULL NAME Wilson Ditch

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED Married WIDOWED OR DIVORCED (If file the word)DATE OF BIRTH Sept 17, 1860
(Month) (Day) (Year)AGE 57 yrs. 12 mos. 12 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) IowaNAME OF FATHER Mr. DitchBIRTHPLACE OF FATHER (City or town, State or foreign country) GermanyMAIDEN NAME OF MOTHER WBIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wes Ditch(ADDRESS) Grandin, Mo.Filed Sept 29, 1917 W. S. McKinney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 28, 1917
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Sept 22, 1917, to Sept 28, 1917, that I last saw him alive on Sept 23, 1917, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) 01 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. H. Hatoon M. D. Sept 29, 1917 (Address) Grandin 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 Homestead, Country DATE OF BURIAL _____ 191__UNDERTAKER W. S. McKinney ADDRESS Grandin, Mo.

PLACE OF DEATH

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

County.....
 Township..... or Registration District No. File No.
 Village..... or Primary Registration District No. Registered No.
 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 not 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. State..... In the.....
 Where was disease contracted if not at place of death?..... yrs. mos. ds.
 Former or usual residence.....

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

1 PLACE OF DEATH

County Carter
 Township Johnson
 or Village
 or City

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

BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

Registration District No. 145 File No.
 Primary Registration District No. 5308 Registered No. 21
 (NO) St. Ward

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

2 FULL NAME

Wilson Litch

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) (Year)

7 AGE
 yrs. mos. da. 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)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 28 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 m. The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. da.

(Signed) M. D.
 (Address) 191

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

15 Filed Sept 29 1917 Alexander R. Johnston Registrar

19 PLACE OF BURIAL OR REMOVAL Homesite Cemetery DATE OF BURIAL Sept 29 1917
 20 UNDERTAKER W E McHenry ADDRESS Granite Hill

Original file, date Sept 29 1917

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

Satisfactory Information Supplied
 SUPPLEMENTARY
 Satisfactory Information Supplied

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), *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.)

31274