

PLACE OF DEATH

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

County Franklin
Township Boles
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 924 File No. 31530
Primary Registration District No. 5411B Registered No. _____

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

FULL NAME Samuel Lawson Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED Single WIDOWED OR DIVORCED (If write the word)

DATE OF DEATH Sep 30, 1917
(Month) (Day) (Year)

DATE OF BIRTH Feb 17, 1878
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1917, to _____, 1917,

AGE 39 yrs. 7 mos. 13 ds. If LESS than 1 day, _____ hrs. or _____ min.?

that I last saw h in dead Oct 1, 1917, and that death occurred, on the date stated above, at 10 m.

OCCUPATION (a) Trade, profession, or particular kind of work laborer

The CAUSE OF DEATH* was as follows:
Sunshot wound in hands of James O'Brian
Verdict of coroner jury
(Duration) _____ yrs. _____ mos. _____ ds.

(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

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

NAME OF FATHER Joseph Thompson

(Signed) Floren Drewel acting coroner. (Address) Labadie Mo

BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont know

MAIDEN NAME OF MOTHER Malinda Hunter

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

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont know

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted If not at place of death? _____

(Informant) John Thompson

Former or usual residence. _____

(ADDRESS) Centaur

PLACE OF BURIAL OR REMOVAL Port Royal DATE OF BURIAL 10/2, 1917

Filed Oct 5, 1917, J. L. Miller REGISTRAR

UNDERTAKER W. Horn ADDRESS Miss Mo

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*, *Composer*, *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.)

1 PLACE OF DEATH

County Franklin
 Township Boles
 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. 924 File No.
 Primary Registration District No. 5411 B Registered No.
 (NO. St. Ward)

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

2 FULL NAME

Samuel Lawson Thompson

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX m 4 COLOR OR RACE w 5 SINGLE MARRIED WIDOWED OR DIVORCED S
 (Write the word)

16 DATE OF DEATH Sept 30 1917
 (Month) (Day) (Year)

6 DATE OF BIRTH
 (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.

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

The CAUSE OF DEATH* was as follows:

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

Gunshot wound in hand of James O'Brien - Verdict of coroner's jury - homicidal
 (Duration) yrs. mos. ds.

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

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

10 NAME OF FATHER

(Signed) M. D.

11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)

191... (Address)

12 MAIDEN NAME OF MOTHER

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

13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant)

Where was disease contracted if not at place of death

(Address)

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

191...

20 UNDERTAKER ADDRESS

15 Filed Oct 5th 1917 J. L. Maher Registrar

Original file, date, 19...

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]

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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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