

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

1 PLACE OF DEATH

County Greene

Township.....

Registration District No. 318

File No. 31601

Village.....

Primary Registration District No. 2001

Registered No. 569

City Springfield (NO Springfield Hosp Ward)

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

2 FULL NAME Powell Weiss

PERSONAL AND STATISTICAL PARTICULARS

✓ MEDICAL CERTIFICATE OF DEATH

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

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

6 DATE OF BIRTH Apr. 8 1906  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from one night, Sept 15 to 16, 1917,  
that I last saw him alive on Sept 16, 1917,  
and that death occurred, on the date stated above, at 4 A. M.

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

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).....

Fracture of Skull  
in accident  
(Duration)..... yrs..... mos. One da

9 BIRTHPLACE (City or town, State or foreign country) Greene Co. Mo.

CONTRIBUTORY (Secondary).....

10 NAME OF FATHER Chris Weiss

(Duration)..... yrs..... mos..... ds.  
(Signed) W. A. Reinhoff M. D.

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

(Address) Greene Co. Mo.

12 MAIDEN NAME OF MOTHER Amie Arnold

\*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) Germany

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) Chris Weiss

Where was disease contracted if not at place of death?.....

(Address) Springfield

Former or usual residence.....

15 SEP 17 1917 Registrar Chas. F. Jaw

19 PLACE OF BURIAL OR REMOVAL Green Lawn DATE OF BURIAL Sept 1917

20 UNDERTAKER Robinson Undert Co ADDRESS 305 N. Walnut

# 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, 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.)

County .....  
 or  
 Township ..... Registration District No. .... File No. 31601  
 or  
 Village ..... Primary Registration District No. .... Registered No. ....  
 or  
 City Springfield (NO. .... St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
 2 FULL NAME Powell Weiss

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE  MARRIED  WIDOWED  OR DIVORCED  (Write the word) 1  
 6 DATE OF BIRTH ..... (Month) ..... (Day) 1 ..... (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) Fell from loft striking his head on piping bolts of a skylight  
 PARENTS  
 10 NAME OF FATHER his head on piping bolts of a skylight  
 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) .....

16 DATE OF DEATH ..... (Month) 16 ..... (Day) 191..... (Year) 7  
 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:  
Fracture of skull, occipital  
Fall from a loft striking his head on a skylight of a garage  
 (Duration) ..... yrs. .... mos. .... ds.  
 CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds.  
 (Signed) A.M. Cullen M. D.  
 ..... 191..... (Address) Springfield, Mo.  
 \*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 .....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) ..... (Address) .....  
 15. Filed Feb 27 191..... Chas. J. Davis Registrar

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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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