

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

PLACE OF DEATH

County Harrison
Township Big Creek
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 358 File No. [REDACTED]
Primary Registration District No. 5503 Registered No. Y 31694

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

FULL NAME William Spencer

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF DEATH Sept 26, 1917
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, _____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

AGE 36 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

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

The CAUSE OF DEATH* was as follows:
Peritonitis Acute

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

38 / 129 / 11
(Duration) _____ yrs. _____ mos. 8 ds.

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

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

NAME OF FATHER Geo. Spencer

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

MAIDEN NAME OF MOTHER Nancy McDonald

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

(Signed) J. B. Bentz M. D.
Sept 30, 1917 (Address) Christen Mo

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Rizzie Spencer

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

(ADDRESS) Manvina Mo

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

Former or usual residence _____

Filed Sept 30, 1917 J. B. Bentz REGISTRAR

PLACE OF BURIAL OR REMOVAL Salem Cem DATE OF BURIAL Sept 27, 1917

UNDERTAKER Neighbors ADDRESS Blount 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*, *peritonaecum*, 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 septicæmia," "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.)

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1 PLACE OF DEATH
 County Nevers
 Township Big Creek
 or
 Village
 or
 City

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

Registration District No. 358 File No. _____
 Primary Registration District No. 5573 Registered No. 8
 (NO. St. Ward)

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

2 FULL NAME William Spencer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>m</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>m</u>
6 DATE OF BIRTH <u>I don't know</u> (Month) (Day) (Year)		
7 AGE <u>36</u> yrs. - mos. - ds.	If LESS than I 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) _____

Filed Sept 30 1917 J. S. Beaulieu
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 26 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:

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

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

(Signed) _____ M. D.
 _____ 191____ (Address)

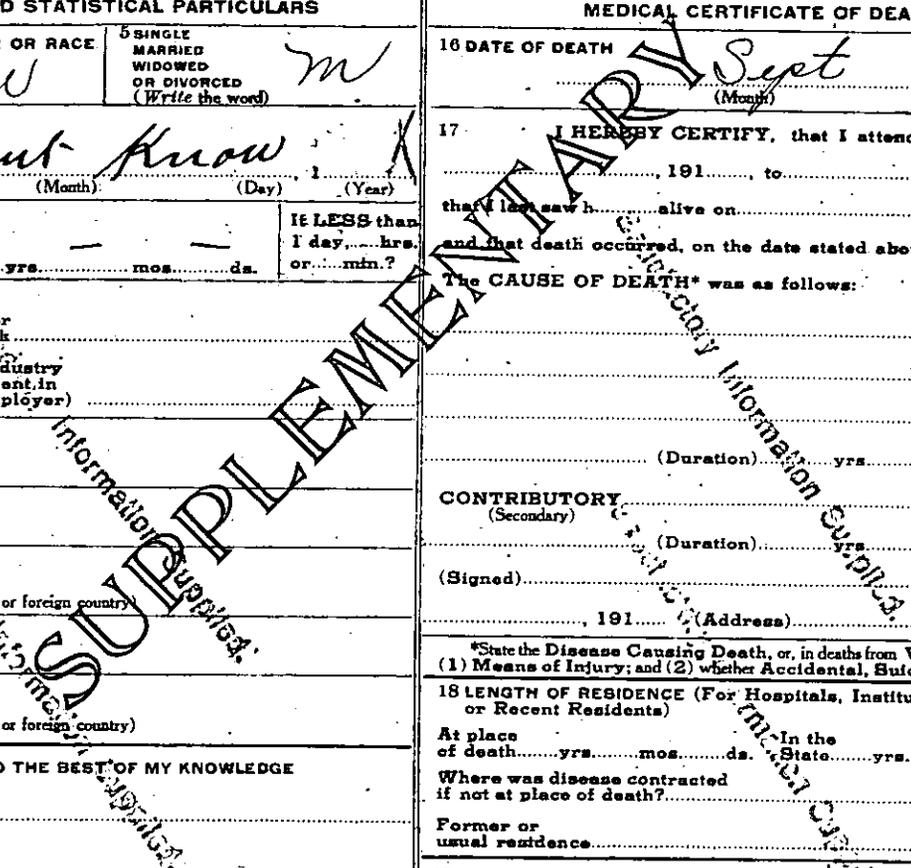
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

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

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 septichaemia," "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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