

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

1 PLACE OF DEATH
County Linn
Township Pawson Creek Registration District No. 503 File No. 15 32358
Village Meadville Primary Registration District No. 4306 Registered No. _____
City Northampton Morehead (NO. _____) St. _____ Ward _____
2 FULL NAME Northampton Morehead (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
6 DATE OF BIRTH Nov 18 1844
(Month) (Day) (Year)
7 AGE 72 yrs 9 mos 27 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work County Judge
(b) General nature of industry, business, or establishment in which employed Public official
9 BIRTHPLACE (City or town, State or foreign country) Howard Co Missouri
10 NAME OF FATHER E. W. Morehead
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Baltimore Md
12 MAIDEN NAME OF MOTHER Sallie A. Page
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15 1917
(Month) (Day) (Year)
17 I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him alive on Sept 14, 1917, and that death occurred, on the date stated above, at 4:00 A.M.
The CAUSE OF DEATH* was as follows:
Paralysis of Heart suffered from initial regurgitation found dead in bed at 6.00 A.M. (Duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) S. O. H. Pridinger M. D. _____, 191____ (Address) Meadville 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 Meadville Mo DATE OF BURIAL Sept 18 1917
20 UNDERTAKER Frank L. Sireley ADDRESS Meadville Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Marsh
(Address) Meadville Mo
15 Filed _____, 191____ Registrar _____

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), *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.)

PLACE OF DEATH

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Linn
Township
or
Village
or
City Meadville (NO. St. Ward)

Registration District No. 503 File No.
Primary Registration District No. 4306 Registered No. 15

2 FULL NAME Worthington Morehead

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

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 1..... (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) | |
| 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, Sept 17 1917 M. Ray Darling
Filed Sept 17 1917 M. Ray Darling
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15 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..... ds.

CONTRIBUTORY (Secondary)
(Duration) yrs..... 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 |

Supplementary Information supplied by Registrar

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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 inter-current) 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.)