

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

1 PLACE OF DEATH
St Clair
County *Chick Level*
Township
or
Village
or
City

Registration District No. *763* File No. *39222-2*
Primary Registration District No. *6006* Registered No. *19*
St. Ward

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

2 FULL NAME *Solomon Booth*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OF RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Widowed*
(Write the word)

6 DATE OF BIRTH *March 22 1834*
(Month) (Day) (Year)

7 AGE *83 8 1* If LESS than 1 day...hrs. or...min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *At Home*
(b) General nature of industry business or establishment in which employed (or employer) *None*

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

PARENTS
10 NAME OF FATHER *Martin Booth*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Penn*
12 MAIDEN NAME OF MOTHER *Simon Shumaker*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Penn*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *W. R. Booth*
Louisa City, Mo
(Address)

15 *Nov 22 1917*
Filed, 1917 *Geo. N. Wright*
Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Nov 23 1917*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Nov 23 1917* to *Nov 23 1917*
that I last saw him alive on *Nov 23 1917*
and that death occurred, on the date stated above, at *6:30 a.m.*
The CAUSE OF DEATH* was as follows:
12 P
97

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *W. E. Taylor* M. D.
Nov 22 1917 (Address) *Ohio, 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 *Concord Cemetery* DATE OF BURIAL *Nov 23 1917*
20 UNDERTAKER *None* ADDRESS

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 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RE-
GIVE A FEE FOR CERTIFICATES
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.

PLACE OF DEATH,
County St. Clair
Township Chalk Level
or
Village _____
or
City _____ (No. _____)

Registration District No. 763

File No. 39442-2

Primary Registration District No. 6006

Registered No. _____

St.: _____ Ward _____

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

FULL NAME Solomon Boots

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED W
(# write 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 Nov 24 1917 Lead Wright REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov 23 1917
(Month) (Day) (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:
apoplexy
64
(Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) W.E. Taylor M. D.
Nov 24 1917 (Address) Louisy City, 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 Ormond Ave. DATE OF BURIAL Nov 25 1917

UNDERTAKER J.E. Austin ADDRESS Louisy City, Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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