

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

1 PLACE OF DEATH  
County Davies  
Township Jackson  
or  
Village  
or  
City Carlton (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 253 File No. 1 727  
Primary Registration District No. 6353 Registered No. \_\_\_\_\_

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

2 FULL NAME Samuel Chevinger

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Sept 11 1846  
(Month) (Day) (Year)

7 AGE 71 yrs. 3 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Mail Carrier  
(b) General nature of industry business, or establishment in which employed (or employer) H-15

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

PARENTS  
10 NAME OF FATHER Mose Chevinger  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) North-Haven  
12 MAIDEN NAME OF MOTHER Martha H. Chevinger  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) North-Haven

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Rollie Murry  
(Address) Gallatin

15 Filed Jan 12 1918 A. Munn Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 11 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 1 1918 to Jan 11 1918  
that I last saw him alive on Jan 1 1918  
and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH\* was as follows:  
Tuberculosis of Kidneys  
30  
Duration 3 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondarily) \_\_\_\_\_  
(Signed) D. P. Hatfield M. D.  
(Address) Jewell Mo

\*State the Disease Causing Death, of in deaths from Violent Causes, state the Cause 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 Restinbury DATE OF BURIAL Jan 12 1918

20 UNDERTAKER J. B. Burren Jameson 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*, *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*, *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.)

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

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

**1 PLACE OF DEATH**

County St. Louis Registration District No. 253 File No. ....  
 Township Jackson Primary Registration District No. 5353 Registered No. 1  
 Village .....  
 City ..... (NO. .... St. .... Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME**

Samuel Dwenger

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX M 4 COLOR OR RACE W 5 SINGLE  MARRIED  WIDOWED  OR DIVORCED  married  
Write the word  
 6 DATE OF BIRTH ..... 191.....  
(Month) (Day) (Year)  
 7 AGE .....  
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 Filed Jan 12 1918 A. G. Minich  
 Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Jan 11 1918  
(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) 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 .....

Original file, date Jan 12 1918

All information called for must be written on this Supplementary Certificate.

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