

PLACE OF DEATH -

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

County Monroe
Township Union
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 390 File No. 4960
Primary Registration District No. 5545 Registered No. 6

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

FULL NAME Dorid Stephens

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE white SINGLE MARRIED Married WIDOWED OR DIVORCED (If ritc the word)

DATE OF DEATH Feb 6, 1918
(Month) (Day) (Year)

DATE OF BIRTH Not known, 1850
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 2, 1918, to Feb 6, 1918, that I last saw him alive on Feb 2, 1918, and that death occurred, on the date stated above, at 8 a m.

AGE 68 yrs. 0 mos. 0 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Minister

Acute Carditis
Access to abdomen
absent (Duration) _____ yrs. _____ mos. _____ ds.

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

Contributory (SECONDARY) 79
(Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER Lauphad Stephens

(Signed) N. A. For M. D.
Feb 7, 1918 (Address) St. arc

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

MAIDEN NAME OF MOTHER Not known

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

*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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mary Wright

Where was disease contracted if not at place of death? _____
Former or usual residence _____

(ADDRESS) St. arc. Mo

PLACE OF BURIAL OR REMOVAL St. arc Cemetery DATE OF BURIAL Feb 7, 1918

Filed Feb 7, 1918 N. A. For REGISTRAR

UNDERTAKER add Reese ADDRESS Minneapolis 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, 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.)

PLACE OF DEATH

County Iron
 Township Union
 or
 Village
 or
 City

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

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

Registration District No. 390 File No.
 Primary Registration District No. 5545 Registered No. 6
 (NO. St. Ward)

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

2 FULL NAME

David Stephens

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 (Month) (Day) (Year) 1 (Month) (Day) (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)

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 Feb 7 1918 M.A. Foss
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) (Year) <u>Feb 6</u> 191 <u>8</u>
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* is as follows:

Acute Cardiac

CONTRIBUTORY (Secondary) Arteriosclerosis
 (Duration) yrs. mos. ds.

(Signed) M.A. Foss M. D.
Feb 7 1918 (Address) St. Louis

*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]

1916

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