

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

1 PLACE OF DEATH

County Greene

Township \_\_\_\_\_

Village \_\_\_\_\_

City Springfield

Registration District No. 318

File No. 8538

Primary Registration District No. 2001

Registered No. 179

(NO. 318 W Locust St. \_\_\_\_\_ Ward)

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

2 FULL NAME W F Greer

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 July 28, 1840  
(Month) (Day) (Year)

7 AGE 77 yrs. 8 mos. 2 ds. If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS  
10 NAME OF FATHER Unknown  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown  
12 MAIDEN NAME OF MOTHER Unknown  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Fay B Greer  
(Address) 318 W Locust St

15 MAR 31 1918  
Filed \_\_\_\_\_, 1918 W F Greer  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 30, 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 22, 1918, to Mar 30, 1918, that I last saw him alive on Mar 30, 1918, and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH\* was as follows:  
97 Uremia due to suppression of urinary secretion  
130  
133C (Duration) 14 yrs. 14 mos. 14 ds.

CONTRIBUTORY arteriosclerosis (Secondary) and old age  
(Duration) not known yrs. not known mos. not known ds.  
(Signed) W F Greer M. D.  
Mar 31, 1918 (Address) Springfield Mo

\*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 not known yrs. not known mos. not known ds. In the State not known yrs. not known mos. not known ds.  
Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Mount Peza Cem DATE OF BURIAL April 1, 1918  
20 UNDERTAKER W F Greer & Co 424 E. Carl 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 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.)

1 PLACE OF DEATH

County Brewer

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

Township

Registration District No. 318

File No.

Village

Primary Registration District No. 2001

Registered No. 179

City

No. 318 N Locust

St. Ward

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

FULL NAME W. H. Grier

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) (Day) 1 (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)

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 AUG 1 - 1918 Filed 1918 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) (Day) 191 (Year) Mar 30 8

17 I HEREBY CERTIFY, that I attended deceased from (Month) (Day) 191 (Year) to (Month) (Day) 191 (Year) that I last saw him (Month) (Day) 191 (Year) and that death occurred, on the date stated above, at (City or town, State or foreign country)

The CAUSE OF DEATH\* was as follows: Septicemia due to suppurative meningitis. Acute nephritis

CONTRIBUTORY (Secondary) Arteriosclerosis and old age (Duration) yrs. mos. ds. (Signed) W. M. C. G. M. D. 191 (Address) Springfield, Mo.

\*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 (Month) (Day) 191 (Year) 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. Satisfactory Information Supplied. Satisfactory Information Supplied.

Original file, date

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

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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 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.)

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