

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

1 PLACE OF DEATH

County Lewis
Township Union
or
Village
or
City

Registration District No. 480 File No. 9620
Primary Registration District No. 5645 Registered No. 9th
(NO. St. Ward)

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

2 FULL NAME

Creston Waterman

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Mar 10 1918
(Month) (Day) (Year)

6 DATE OF BIRTH Feb 25 1909
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 14th 1918, to 1918, that I last saw h..... alive on..... 191..... and that death occurred, on the date stated above, at..... m.

7 AGE 15 yrs. 11 mos. 12 ds. If LESS than 1 day..... hrs. or..... min.?

The CAUSE OF DEATH* was as follows:
Pneumonia
1918
(Duration)..... yrs..... mos..... ds.

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

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds.
(Signed)..... M. D.
191..... (Address).....

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

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER Mattie Walker
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) 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..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted if not at place of death?
Former or usual residence.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Chas Waterman
(Address) La Grange Mo

19 PLACE OF BURIAL OR REMOVAL Dover bury DATE OF BURIAL Mar 11, 1918

15 Filed Mar 11 1918 W. J. Ellery Registrar
By W. J. Ellery

20 UNDERTAKER A. R. Roberts ADDRESS La Grange Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

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 "Asithenia," "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.

PLACE OF DEATH

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

Registration District No. 480 File No. _____
Primary Registration District No. 5645 Registered No. 9

FULL NAME Oriston Waterman Illegitimate

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OF RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ If LESS than 1 day, _____ hrs _____ min. or _____ mos. _____ ds.

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 March 11th 1918 W L Elley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 10, 1918 (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: Branch Pneumonia (Branch Pneumonia)

Contributory (SECONDARY) Pulmonary Tuberculosis (Duration) 23 yrs. mos. ds. (Signed) Wm Elley M.D. March 11 1918 (Address) Salmon

*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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

Supplementary Information
SUPPLEMENTARY
Supplementary Information

Revised United States Standard Certificate of Death

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

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