

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 10102

1 PLACE OF DEATH

County Pettis
Township Dresden
or
Village
or
City..... (NO..... St..... Ward)

Registration District No. 672 File No.
Primary Registration District No. 5985 Registered No. 3

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

2 FULL NAME Wilfred Fowler

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 Aug 4 1913
(Month) (Day) (Year)

7 AGE 4 yrs 7 mos 28 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) Dresden Mo.

10 NAME OF FATHER Walter B Fowler

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kenns

12 MAIDEN NAME OF MOTHER Bernice Shroyer

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ills

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) D. E. Shroyer

(Address) Dresden Mo.

15 Filed 4-9-18 A. B. Ferguson Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 31 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from 3/15 1918 to 3/31 1918 that I last saw him alive on 3/30 1918 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Menigitis
77A (Duration)..... yrs..... mos. 5 ds.

CONTRIBUTORY measles (Secondary) (Duration)..... yrs..... mos. 14 ds.

(Signed) D. E. Shroyer M. D. 3/31 1918 (Address) Bedalia

*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 Dresden Cemetery DATE OF BURIAL April 1 1918

20 UNDERTAKER B. F. Parker ADDRESS La Monte

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

County
 Township or
 Village or
 City (NO)
 Registration District No. File No.
 Primary Registration District No. Registered No.
 St. Ward

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

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M	4 COLOR OR RACE C	5 SINGLE MARRIED WIDOWED DIVORCED (WRITE the word)	6 DATE OF BIRTH 1918 10 19	7 AGE 19
			(Month) (Day) (Year)	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)

16 DATE OF DEATH

..... (Month) (Day) 191..... (Year)

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* was as follows:

MEDICAL CERTIFICATE OF DEATH

CONTRIBUTORY

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

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

*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

DATE OF BURIAL
, 191.....

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. The statement of OCCUPATION is very important.

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

1 PLACE OF DEATH
 County St. Louis
 Township Madison
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

Registration District No. 672 File No. _____
 Primary Registration District No. 5485 Registered No. 3

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

2 FULL NAME Wynford Fowler

PERSONAL AND STATISTICAL PARTICULARS

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

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

7 AGE _____ yrs. _____ 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 49- 1918 W B Ferguson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 31 1918
 (Month) (Day) (Year)

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* was as follows:
Measles
not epidemic - terminal
of measles.
 (Duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY (Secondary) Measles
 (Duration) _____ yrs. _____ mos. 14 ds.
 (Signed) Dr. Dyke M. D.
 _____ 191_____ (Address) Deolalia 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 _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191_____

20 UNDERTAKER _____ 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, 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 septichaemia," "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.)