WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

10236

1 PLACE OF DEATH

County Randolph

Township ..... Registration District No. 735 File No. .....

or

Village ..... Primary Registration District No. 3034 Registered No. 66

or

City Moberly (NO. Woodland Hospital St.; 2nd Ward)

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

2 FULL NAME Wilfred Philpott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) single

6 DATE OF BIRTH Jan. 9th (Month) 1902 (Day) (Year)

7 AGE 6 yrs. 2 mos. 19 ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER Horace Philpott

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

12 MAIDEN NAME OF MOTHER Nellie Beazley

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. F. Keeley

(Address) Moberly Mo.

15 Filed [illegible], 191.. B. E. Cuppaidge Registrar

MEDICAL CERTIFICATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended deceased from Mar. 15th, 1918, to Mar. 30th, 1918, that I last saw him alive on Mar. 30th, 1918, and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Meningitis
7
89A
79A (Duration) ..... yrs. ..... mos. two ds.

CONTRIBUTORY (Secondary) Otitis media
(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) C. L. Dodson D.O. ~~M.D.~~

Apr. 1st, 1918 (Address) Moberly 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. 3 ds. In the State 6 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? At home

Former or usual residence Moberly, Mo.

19 PLACE OF BURIAL OR REMOVAL Salisbury Mo.

DATE OF BURIAL 4/1 — 1918

20 UNDERTAKER Martin & Mahan

ADDRESS Moberly 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, 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 *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.)

This boy developed on otitis media during an attack of measles. He recovered from measles and was out of bed. The ear continued to discharge for some days and finally stopped. In a day or two the pain returned in the ear with fever and evidence of involvement of the mastoid. I had the mastoid opened with the hope of establishing drainage. He died on the third day after meningitis symptoms became pronounced enough to ~~diff~~ identify as such.

C. L. Dodson, M.D.

Form V. S. No. 03.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

The enclosed certificate is defective for the reason that the term as given is indefinite. If *epidemic*, please so state. When *terminal* or *symptomatic*, the disease in which it occurred should be named. *Tubercular Meningitis* should be reported as such. Not tuber

Please correct, sign and return, together with this card.

F. Dodson

C. J. KAISER,
Statistician.

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.

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

1 PLACE OF DEATH

County Randolph

Township ..... Registration District No. 735 File No. .....

or Village ..... Primary Registration District No. 3034 Registered No. 66

or City Moberly (No. Wood Land Hosp St.; 2 Ward)

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

2 FULL NAME Wilfred Philpott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (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 Apr 2, 1918 B. E. Cupsaidge Registrar

Satisfactory Information Supplied.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mch - 30, 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:

Meningitis 61

Was not epidemic.

Resulted from otitis media

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis Media

(Duration) — yrs. — mos. 16 ds.

(Signed) C. L. Dodson M.D.

....., 191... (Address) 205½ Reed St.

*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.]

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