

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**

**1 PLACE OF DEATH**

County Adair  
Township Liberty  
or  
Village  
or  
City (NO. .... St. .... Ward)

Registration District No. 978  
Primary Registration District No. 5008

File No. 11998  
Registered No. ....

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

**2 FULL NAME** William Stone

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX Male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDDED OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Aug 27 1893  
(Month) (Day) (Year)

7 AGE 24 yrs. 8 mos. 27 ds. IF LESS than 1 day, .... hrs. or .... min.?

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

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

**PARENTS**  
10 NAME OF FATHER George Stone  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Idaho  
12 MAIDEN NAME OF MOTHER Mary Holt  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Glen Schockley  
(Address) Nowinger mo

15 Filed 4/5 1918 W. E. Munn  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH April 4 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 31, 1918, to April 4, 1918, that I last saw him alive on April 3, 1918, and that death occurred, on the date stated above, at 12:30 a.m.  
The CAUSE OF DEATH\* was as follows: 1151  
Septic Pneumonia

(Duration) .... yrs. .... mos. 5 ds.

CONTRIBUTORY (Secondary) (Duration) .... yrs. .... mos. .... ds.  
(Signed) M. E. Depler M. D.  
April 4, 1918 (Address) Nowinger 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 Nowinger Cemetery DATE OF BURIAL 4/5, 1918

20 UNDERTAKER W. E. Wallman ADDRESS Nowinger 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, 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.)

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1 PLACE OF DEATH

County Adair  
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City

Registration District No. 978 File No.  
Primary Registration District No. 5008 Registered No.  
City (NO. St. Ward)

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

2 FULL NAME

William Stone

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Apr 4, 1918  
(Month) (Day) (Year)

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

17 I HEREBY CERTIFY, that I attended deceased from 3/27/18, 1918, to Apr 4, 1918, that I last saw him alive on Apr 4, 1918, and that death occurred, on the date stated above, at 10:30 AM m.

7 AGE  
If LESS than 1 day.....hrs. or.....min.?  
.....mos.....ds.

The CAUSE OF DEATH was as follows:

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

Acute Pneumonia  
Following an injection  
of throat, not result of  
an injury  
(Duration).....yrs.....mos.....ds.

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

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

10 NAME OF FATHER

(Signed) M. E. DePue M. D.  
4/4, 1918 (Address) Moving

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

\*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

12 MAIDEN NAME OF MOTHER

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

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

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death?

(Informant)

Former or usual residence

(Address)

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

15 Filed..... 191..... Registrar

20 UNDERTAKER ADDRESS

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Satisfactory Information Supplied.

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"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 child-birth 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.)