

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

1 PLACE OF DEATH

County Green

Township \_\_\_\_\_

or \_\_\_\_\_

Village \_\_\_\_\_

or \_\_\_\_\_

City Springfield

Registration District No. 318

Primary Registration District No. 2001

Registered No. 204

(No. St. John's Hospital Ward)

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

File No. 12809

Registered No. 204

Ward

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

Ward

2 FULL NAME William White Biggs

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Sept 5 1863  
(Month) (Day) (Year)

7 AGE 64 yrs 6 mos. 6 ds. If LESS than 1 day, hrs. or min.?

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

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

10 NAME OF FATHER Alvin Biggs

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

12 MAIDEN NAME OF MOTHER Nancy Robertson

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Hill Schaefer (Address) 300 N. Walnut.

15 APR 13 1918 Geo F. Jew Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 12 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 25<sup>th</sup>, 1918, to April 12<sup>th</sup>, 1918, that I last saw him alive on April 11, 1918, and that death occurred, on the date stated above, at 5:25 m. The CAUSE OF DEATH\* was as follows:

Papilloma of Bladder

(Duration) Several months yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. H. Pearson M. D.

April 12, 1918 (Address) SPRINGFIELD

\*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 Brick Church Cem DATE OF BURIAL Apr. 14, 1918

20 UNDERTAKER Schaefer Undert Co ADDRESS 300 N. Walnut.

# 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, peritoneum*, 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.)

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County Craw

Township  
or  
Village  
or  
City

Registration District No. 318  
Primary Registration District No. 2001

File No. ....  
Registered No. 504

(No. .... St. .... Ward)

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

2 FULL NAME William White Biggs

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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 AUG 1 1918 Edwin A. James  
Filed 1918 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 12 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Satisfactory to Satisfactory 1918 to 1918 that I last saw him alive on 1918 and that death occurred, on the date stated above, at Supposed m.

The CAUSE OF DEATH\* was as follows:  
Tumor of Bladder  
Had legs all in several weeks  
Barren to Patient's statement  
Two weeks to my knowledge  
(Duration) ..... yrs..... mos..... ds.

CONTRIBUTORY Don't know  
(Secondary) ..... (Duration) ..... yrs..... mos..... ds.  
M. D. 8/12/18  
AUG 1 1918 (Address) SPRINGFIELD MO

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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? .....

19 PLACE OF BURIAL OR REMOVAL ..... DATE OF BURIAL ..... 1918

20 UNDERTAKER ..... ADDRESS .....

Deane Johnson  
Deputy Registrar

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12809  
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