

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

1 PLACE OF DEATH

County Saline  
Township.....  
or  
Village.....  
or  
City Slater (NO. .... St.: .... Ward)

Registration District No. 299  
Primary Registration District No. 4479

File No. ....  
Registered No. 15796  
26

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

2 FULL NAME Robert Henry Smith

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M  
4 COLOR OR RACE col  
5 SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)  
6 DATE OF BIRTH Feb 16 1854  
(Month) (Day) (Year)  
7 AGE 64 yrs. 3 mos. 3 ds.  
If LESS than 1 day, hrs. or min.?

16 DATE OF DEATH Apr 19 1918  
(Month) (Day) (Year)  
17 I HEREBY CERTIFY, that I attended deceased from Mar 10 1918 to Apr 19 1918  
that I last saw him alive on Apr 18 1918  
and that death occurred, on the date stated above, at 12:20 m.  
The CAUSE OF DEATH\* was as follows:

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

Cystitis  
1358  
(Duration) 6 yrs. 0 mos. 0 ds.

9 BIRTHPLACE (City or town, State or foreign country) Mo  
10 NAME OF FATHER Grandison Sargent  
11 BIRTHPLACE OF FATHER (City, or town, State or foreign country) Va  
12 MAIDEN NAME OF MOTHER Best  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) known

CONTRIBUTORY (Secondary) .....  
(Duration) yrs. mos. ds.  
(Signed) Dr. Arthur M. D.  
Apr 19 1918 (Address) Slater Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) T. M. Smith  
(Address) Salina 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.....

15 Filed 4119 1918  
S. W. M. Smith  
Registrar

19 PLACE OF BURIAL OR REMOVAL Salina Mo  
DATE OF BURIAL Apr 22 1918  
20 UNDERTAKER W. C. Brothers  
ADDRESS Slater 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 *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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CERTIFICATE OF DEATH

1 PLACE OF DEATH  
County Saline  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. 799 File No. \_\_\_\_\_  
Primary Registration District No. 4479 Registered No. 26

2 FULL NAME Robert Henry Smith St. \_\_\_\_\_ Ward \_\_\_\_\_

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

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH \_\_\_\_\_ 191\_\_\_\_  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 24

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 \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_ Registrar \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 19 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 \_\_\_\_\_

The CAUSE OF DEATH was as follows:  
Cystitis  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs \_\_\_\_\_ mos \_\_\_\_\_ ds

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

\*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, \_\_\_\_\_

Dr does not know of any Contributory Cause  
Pds  
O. J. KAISER, Statistician.

Satisfactory information supplied

Satisfactory information supplied

Satisfactory information supplied

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15796  
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