

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

24264-a

**1. PLACE OF DEATH**

County Laclede Registration District No. 277  
Township Smith Primary Registration District No. 6611  
City (No. ....) St. .... Ward .....

File No. 23699-1  
Registered No. ....  
St. .... Ward .....

**2. FULL NAME**

Benjamin Emerick  
(a) Residence. No. .... St. .... Ward .....

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 24 1834

7. AGE 84 YEARS MONTHS 11 DAYS 19 If LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

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

BIRTHPLACE (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)

10. NAME OF FATHER George Emerick

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Elizabeth Siler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

14. INFORMANT Chase Mooney  
(Address) Stoutland Mo.

15. FILED 10-2-1928 C. E. Carlton REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1928

17. I HEREBY CERTIFY That I attended deceased from did not receive medical  
that I last saw h. .... alive on as a, 19...., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Senility  
110  
1600

**CONTRIBUTORY (SECONDARY)**

164

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D.  
, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cox Crossing Cem. DATE OF BURIAL July 14 1928

20. UNDERTAKER Robt. Mansfield ADDRESS Deeper

VITAL

PARENTS

# 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 neoplasma); *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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: *Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus.*" But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

1  
Aug the 22 1928

the State Board of Health  
I have received Father's  
Death Certificate and  
I taken it over to my  
Lawyer and he took  
it over and said  
that would never do at  
all to send it in since  
widowed as Father was  
not a widowed he was  
married and a living wife  
my mother at that time  
of his Death mother  
I lived 2 or 3 years after  
my Father Died they  
were both in the 80 age  
mother was sick and Father  
both they lived in St. Regis  
Montana on a ranch  
& this was no one but my

23699-1

we have to have  
this stificate strictly  
write charge Widowed  
to married

Place on State of  
Pennsylvania  
on John Gorge Emerich  
in Stid of Lon  
Unknown

we sent you our  
first stificate

my Lawyer says  
this stificate no good  
in less we have the  
2 wordes are  
fit - changed play  
fit it up send back

23699-1

Wm  
if  
you keep the  
money  
I received it Back

23699-1

if you just place  
John on to gorge  
I can send it  
but John has  
to be signed it  
no good to me  
signed gorge  
to fix. A kind  
happ soon as  
possible I just  
gota few days to  
get it on file

Lambert

N 37 at 2640  
RR 4 - Box 76

He send back soon  
he shure map

out John Gorge

John can be added  
on to gorge

& can't use  
Stificate if it ant

made out John Gorge

Emerick  
in stid of gorge  
gorge is his middle  
name

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**PLACE OF DEATH.**

County Laclede Registration District No. 277 File No. \_\_\_\_\_  
Township Smith Primary Registration District No. 5611 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Benjamin Emerick  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
*(write the word)*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 24 - 1834

AGE YEARS MONTHS DAY 83 10 18  
IF LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

Ohio  
(STATE OR COUNTRY)

**10. NAME OF FATHER**

John George Emerick

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

Unknown  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

Elizabeth Silver

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

Unknown  
(STATE OR COUNTRY)

**14. INFORMANT**

Chase Mooney  
(Address) Stoutland Mo.

15. FILED 10-11-25 Lo E. Loester  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 10 1919

17. I HEREBY CERTIFY That I attended deceased from July 10 1919 to July 12 1919  
that I last saw him, alive on July 12 1919, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Stroke  
118  
CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? Place of Death

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) W. Peck M. D.

. 19 (Address) Stoutland Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Cox Crossing Cem. July 14 1919

**20. UNDERTAKER**

**ADDRESS**

Robert Mansfield  
acting undertaker Sleeper Mo.

23699-1