

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

1 PLACE OF DEATH

County Ozark
Township Bayou
or
Village
or
City (NO.) (St.) (Ward ..)

Registration District No. 647
Primary Registration District No. 5857

File No. 24070
Registered No. 7

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

2 FULL NAME Elmer Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)
6 DATE OF BIRTH <u>March</u> , 19 <u>1895</u> (Month) (Day) (Year)		
7 AGE <u>23</u> yrs. <u>3</u> mos. <u>25</u> ds.		If LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Willowsprings Mo.</u>		
PARENTS	10 NAME OF FATHER <u>Geo. Green</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Willowsprings Mo</u>	
	12 MAIDEN NAME OF MOTHER <u>Fessith Branson</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo. Co. Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
July, 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 27, 1918, to July 2, 1918, that I last saw him alive on July 2, 1918, and that death occurred, on the date stated above, at 11:30 pm.

The CAUSE OF DEATH* was as follows:
Valvular heart lesion which I first discovered on June 25

(Duration) yrs. mos. ds.

CONTRIBUTORY Intermittent fever
(Secondary) and refused to take food for
(Duration) yrs. mos. 10 ds.

(Signed) C. A. Beach M.D.
1, 3, 1918 (Address) Elijah 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.....

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fessith Green
(Address) Elijah Mo

15 Filed July 3, 1918
Registrar

19 PLACE OF BURIAL OR REMOVAL <u>White Oak Cemetery</u>	DATE OF BURIAL <u>7, 3</u> , 19 <u>18</u>
20 UNDERTAKER <u>Wm. Minner</u>	ADDRESS <u>Elijah Mo</u>

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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.)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County Ozark
Township Rayon
Village
City

Registration District No. 647 File No. 24070
Primary Registration District No. 2867 Registered No. 7

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

2 FULL NAME Elmer Greed

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 March 7 1896
(Month) (Day) (Year)

7 AGE 23 yrs. 3 mos. 4 ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS
10 NAME OF FATHER James Green
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Willow Springs Mo
12 MAIDEN NAME OF MOTHER Fenith Cronson
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mt. Grove Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Green
(Address) Elijah Mo

15 Filed July 5 1918 M. F. Greed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 27 1918 to July 9 1918 that I last saw alive on July 9 1918 and that death occurred, on the date stated above, at 11:45 P. m.

18 The CAUSE OF DEATH* was as follows:
Abnormal heart lesions which I first discovered on June 27 - 1918
(Duration) 14 yrs. 3 mos. 4 ds.

19 CONTRIBUTORY (Secondary) Intermittent fever and refusal to take food for 10 days
(Signed) E. A. Beach, P.S., M. D.
(Address) Elijah Mo
7-32, 1918

*State the Disease Causing Death, or, in death 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 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.
Where was disease contracted if not at place of death?
Former or usual residence 1

19 PLACE OF BURIAL OR REMOVAL White oak cemetery DATE OF BURIAL 7-3 1918

20 UNDERTAKER Chas. B. Minson ADDRESS Elijah Mo

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

1 PLACE OF DEATH

County
 Township Registration District No. File No.
 or
 Village Primary Registration District No. Registered No.
 or
 City (NO.) St. Ward)
 If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH (Month) 1 (Year)
 IF LESS than
 1 day hrs.
 or min.?

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)

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 (Month) 191 (Day) 191 (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:

CONTRIBUTORY (Secondary) yrs. mos. ds. (Duration)
 (Signed) (Duration) yrs. mos. ds. (Duration) M. D. (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, 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