

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

1 PLACE OF DEATH

County Lafayette

Township \_\_\_\_\_

Village \_\_\_\_\_

City Lexington

Registration District No. 461

Primary Registration District No. 3024

(NO. 147 South St. 2 Ward)

File No. 1029781

Registered No. \_\_\_\_\_

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

2 FULL NAME Willard D. Ketting

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 11 (Month) 13 (Day) 1867 (Year)

7 AGE 51 yrs. 11 mos. 26 ds. H 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) Syracuse Indiana

PARENTS 10 NAME OF FATHER Edwin Ketting 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio 12 MAIDEN NAME OF MOTHER Nancy Dixon 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Eava Ketting (Address) 1720 Park Hill mo.

15 Filed Sept 21 1918 J. L. Cope Registrar

7 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 21 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 20 1918 to Sept 21 1918 that I last saw him alive on Sept 21 1918 and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH\* was as follows:  
Fracture of Skull.  
accidental  
2:10 P  
2:10 AM (Duration) yrs. mos. ds.

CONTRIBUTORY Fracture of Skull (Secondary) Accidentally (Duration) yrs. mos. ds. (Signed) W. J. Hayes (Address) Lexington Mo.

\*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 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 Syracuse Ind DATE OF BURIAL away 20 UNDERTAKER Ernest Regert ADDRESS Lexington Mo

This statement of OCCUPATION is very important. Do not omit to fill in, unless it may be properly classified.

# 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 "Asthena," "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 septichaemia," "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 Boone Registration District No. 461 File No. 108  
 Township Boone Primary Registration District No. 3024 Registered No. 108  
 City Boone (No.       ) St.        Ward       

2. FULL NAME Wesley D. Ketrug  
 (a) Residence No.        St.        Ward         
 (Usual place of abode)  
 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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (For use the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1918

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

17. I HEREBY CERTIFY, That I attended deceased from       , 19 18, to       , 19 18, that I last saw him        alive on       , 19 18, and that death occurred, on the date stated above, at        m.

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

fracture of skull  
accidental

8. OCCUPATION OF DECEASED

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

CONTRIBUTORY (SECONDARY) fall from chimney on auto  
accidental

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)       

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:       

DID AN OPERATION PRECEDE DEATH?        DATE OF       

WAS THERE AN AUTOPSY?       

WHAT TEST CONFIRMED DIAGNOSIS?       

(Signed) R. Temple Payne Coroner M. D.  
 , 19 18 (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.)

14. INFORMANT (Address)       

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

15. FILED Sept 21 1918 J. D. Cape REGISTRAR

20. UNDERTAKER        ADDRESS       

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

MISSOURI STATE BOARD OF HEALTH  
SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Error statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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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.

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