

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

1 PLACE OF DEATH

County Marion
 Township South River Registration District No. 5-48 File No. 34780
 or
 Village Primary Registration District No. 5741 Registered No. 65
 or
 City (NO. _____ St.; _____ Ward)

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

2 FULL NAME Richard Lonlace

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Sept 6 1911</u> (Month) (Day) (Year)		
7 AGE <u>7</u> yrs. <u>1</u> mos. <u>19</u> ds.		IF LESS than 1 day.....hrs. or.....min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>School child</u> (b) General nature of industry business or establishment in which employed (or employer)		
9 BIRTHPLACE (City or town, State or foreign country) <u>Ely Mo</u>		
PARENTS	10 NAME OF FATHER <u>Cliff Lonlace</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u>	
	12 MAIDEN NAME OF MOTHER <u>Emma Gilker</u>	
	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Cliff Lonlace
 (Address)* Ely Mo

15 Filed Oct. 26 1918 J. B. H.
S. J. H.
 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 25 1918
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 24 1918 to Oct 25 1918, that I last saw him alive on Oct 25 1918, and that death occurred, on the date stated above, at 72 m. The CAUSE OF DEATH* was as follows:
Laryngeal Diphtheria
 10
 (Duration) yrs. mos. 3 ds.
 CONTRIBUTORY Diphtheria
 (Secondary) (Duration) yrs. mos. 3 ds.
 (Signed) J. M. Morrison M. D.
Oct 26 1918 (Address) Moscow 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.....

19 PLACE OF BURIAL OR REMOVAL <u>Talinger Mo</u>	DATE OF BURIAL <u>Oct 27 1918</u>
20 UNDERTAKER <u>Orrest Lewis Talinger Mo</u>	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REPRODUCED FROM THE ORIGINAL RECORDS OF THE MISSOURI STATE BOARD OF HEALTH. THIS IS A PERMANENT RECORD.

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, more precise specification is necessary. Never report "Laborer" or "Foreman" 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 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." (Recommended by Committee on Nomenclature of the American Medical Association.)