

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

42065-A  
472

1 PLACE OF DEATH

County New Madrid  
Township Shannon  
Village New Madrid  
City New Madrid (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 604  
Primary Registration District No. 5802

File No. \_\_\_\_\_  
Registered No. 472

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

2 FULL NAME Harris Frank Stilman

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	MARITAL STATUS <u>Married</u> (Write the word)
DATE OF BIRTH <u>Feb 23 1881</u> (Month) (Day) (Year)		
AGE <u>37 yrs. 8 mos. 17 ds.</u>		IF LESS than 1 day, hrs. or min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Farm Sec.</u>		
BIRTHPLACE City or town, State or foreign country <u>Fort Madison Ia</u>		
10 NAME OF FATHER <u>Ross Stilman</u>	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't Know</u>	
12 MAIDEN NAME OF MOTHER <u>"</u>	13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>"</u>	

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 8 1918  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 4 1918 to Nov 8 1918 that I last saw him alive on Nov 7 1918 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH\* was as follows:  
Influenza

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) [Signature] M. D.  
(Date) Nov 9 1918 (Address) New Madrid 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. Stilman  
(Address) New Madrid, Mo.

19 PLACE OF BURIAL OR REMOVAL New Madrid Co. DATE OF BURIAL 11-9-1918

20 UNDERTAKER O. B. Richards ADDRESS New Madrid

Filed 6-14 1928 W. B. Cannon Registrar

# 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) *Colton 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  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County New Madrid Registration District No. 604 File No. ....  
 Township ..... Primary Registration District No. 4358 Registered No. 472  
 City " " (No. ....) St. .... Ward)

**2. FULL NAME**

Haisie Frank Stilman  
 (a) Residence. No. .... St. .... Ward. .... (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**

SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W  
 6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

**DATE OF BIRTH (MONTH, DAY AND YEAR)**

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

**OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) .... yrs. .... mos. .... ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
 (c) Name of employer

**BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**10. NAME OF FATHER**

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

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

Unknown

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

(STATE OR COUNTRY) Unknown

**14. INFORMANT**

(Address)

FILED 6/14/20 W. B. Bannett REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8 19 18

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

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

CONTRIBUTORY (SECONDARY) ..... (duration) .... yrs. .... mos. .... ds.

**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)....., 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.

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

19

**20. UNDERTAKER** ADDRESS

PARENTS

**SUPPLEMENTARY**

41065A