

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Scott
Township Richland
or
Village
or
City Sikeston (NO. St. Ward)

Registration District No. 821 File No. 175 50745
Primary Registration District No. 6070 Registered No.

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

2 FULL NAME Alois May Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE Child
MARRIED
WIDOWED
OR DIVORCED
(Write the word)
6 DATE OF BIRTH June 23 1916
(Month) (Day) (Year)
7 AGE 2 yrs. 5 mos. 14 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) Sikeston Mo

PARENTS
10 NAME OF FATHER Billie Baker
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Mary Cooper
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Billie Baker
(Address) Sikeston Mo

15 Filed 12/14 1918 W.C. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 7 1918
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 28 1918 to Dec 7 1918, that I last saw him alive on Dec 7 1918 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
11AP pneumonia
109M
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) Dr. A. L. Stepp M. D.
Dec 8 1918 (Address) Sikeston 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 Dogwood Ridge Mo DATE OF BURIAL Dec 8 1918

20 UNDERTAKER H. H. Walsh ADDRESS Sikeston Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 6 MARRIED 7 WIDOWED OR DIVORCED (Write the word) | | |
| 6 DATE OF BIRTH | (Month) | (Day) | (Year) |
| 7 AGE | yrs. mos. da. | (Day) | (Year) |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work..... (b) General nature of industry business, or establishment in which employed (or employer)..... | If LESS than 1 day..... hrs. or..... min.? | | |
| 9 BIRTHPLACE (City or town, State or foreign country) | yrs. mos. da. | | |
| 10 NAME OF FATHER | (Duration) yrs. mos. da. | | |
| 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) | (Duration) yrs. mos. da. | | |
| 12 MAIDEN NAME OF MOTHER | (Address) M. D. | | |
| 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) (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)

(Signed) (Duration) yrs. mos. da.
 (Duration) yrs. mos. da.
 191..... (Address)

*Specify 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. da. In the State..... yrs. mos. da.
 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

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

1. PLACE OF DEATH

County Scott Registration District No. 821 File No. _____
 Township Richland Primary Registration District No. 6070 Registered No. 175
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Elsie May Baker

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) child

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 1918

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, 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 _____ mds.

Pneumonia influenza 10
 (duration) yrs. mos. ds.

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) _____ (duration) yrs. mos. ds.

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) _____, M. D. _____, ID (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 DATE OF BURIAL _____ 19____

20. UNDERTAKER ADDRESS _____

14. INFORMANT (Address) _____
 15. FILED 12/14 1918 W. E. Dennis REGISTRAR

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. OCCUPATIONAL IS VERY IMPORTANT.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

50745

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, 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," "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.