

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty Stone

Township _____

or Village Galena Mo.

or City _____ (NO. _____ St.; _____ Ward)

Registration District No. 843File No. 50848Primary Registration District No. 4513

Registered No. _____

FULL NAME

Thomas Carson

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED married
WIDOWED OR DIVORCED
(Write the word)DATE OF BIRTH Aug. 27, 1841
(Month) (Day) (Year)AGE 77 yrs. 3 mos. 28 ds. If LESS than 1 day, ___ hrs. or ___ min.?OCCUPATION (a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) BIRTHPLACE (City or town, State or foreign country) PennsylvaniaNAME OF FATHER Abraam CarsonBIRTHPLACE OF FATHER (City or town, State or foreign country) Pa.MAIDEN NAME OF MOTHER Elizabeth ChambersBIRTHPLACE OF MOTHER (City or town, State or foreign country) West Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. S. Carson(ADDRESS) Woodburn IowaFiled 12/25, 1918. Henson

REGISTRAR

DATE OF DEATH Dec. 25, 1918
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Dec. 25, 1918, to Dec. 25, 1918, that I last saw him alive on Dec. 25, 1918, and that death occurred, on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:

Burn
(Duration) 1 yrs. 12 hrs.Contributory
(SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.(Signed) Henson M. D.
12/25, 1918 (Address) Galena Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 _____

PLACE OF BURIAL OR REMOVAL Woodburn Iowa DATE OF BURIAL Dec. 30, 1918UNDERTAKER C. J. Manley ADDRESS Aurora Mo.

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE _____ MARRIED _____
 OR DIVORCED _____ (If ~~the~~ the word)

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

AGE _____ yrs. _____ mos. _____ ds.

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

BIRTHPLACE (City or town, State or foreign country) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____ (ADDRESS) _____

Filed _____, 191____, REGISTRAR _____

DATE OF DEATH _____ (Month) _____ (Day) _____ (Year) _____
MEDICAL CERTIFICATE OF DEATH

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:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.

_____ (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.
 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 _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

UNDERTAKER _____ ADDRESS _____

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

1: PLACE OF DEATH

County Stone Registration District No. 843 File No. _____
 Township Galena Primary Registration District No. 4513 Registered No. _____
 City Galena (No. _____) St. _____ Ward _____

2: FULL NAME: Thomas Carson

(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

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

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

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 _____

9. 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 _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 12/25 1919 d. Henson REGISTRAR

MEDICAL CERTIFICATE OF DEATH:

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 25 1918

17. I HEREBY CERTIFY; That I attended deceased from _____, 19____, to _____, 19____, and that death occurred on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Burn
accidental, Poured Coal oil into a heating stove
 (duration) _____ yrs. _____ mos. _____ ds.

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) d. Henson, M. D.

12/25, 1919 (Address) Galena Mo.

*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 _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES OF DEATH

SUPPLEMENTARY

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*; *Broncho-pneumonia* ("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.

5884