

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 4766

1 PLACE OF DEATH

County Cates

Township _____

Village _____

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

Registration District No. 53

File No. _____

Primary Registration District No. 8005

Registered No. 14

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

2 FULL NAME

Leo Richard Engels

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH July 17, 1919
(Month) (Day) (Year)

7 AGE 9 yrs. 9 mos. 9 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) Rich Hill Mo.

PARENTS
10 NAME OF FATHER Leo R. Engels
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Rich Hill Mo.
12 MAIDEN NAME OF MOTHER Estella Ransom
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rich Hill Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo Engels
(Address) Rich Hill Mo.

15 Filed Feb 27 9 1919 Daniel J. [unclear] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26, 1919
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 17, 1919 to July 26, 1919 that I last saw him alive on July 26, 1919 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
Tetanus
7 yr
1610
(Duration).....yrs.....mos. 6 ds.

CONTRIBUTORY (Secondary) _____
(Duration).....yrs.....mos.....ds.
(Signed) J. W. Hallen M. D.
(Address) Rich Hill 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 Brown Farm DATE OF BURIAL Feb 27, 1919

20 UNDERTAKER None ADDRESS _____

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 "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 child-birth 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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH
 County Bates Registration District No. _____ File No. 4706
 Township _____ Primary Registration District No. _____ Registered No. _____
 City Rich Hill No. _____ St. _____ Ward _____

2. FULL NAME Leo Richard Eagles
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (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 S
 (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 26 1919
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw _____, live on _____, 19____, and that death occurred on the date stated above, at _____, Mo.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
with the cause given
infection was respiratory
of cold

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day hrs. or min.

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) W. H. Allen M. D.
 , 19____ (Address) Rich Hill Mo

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) _____

PARENTS

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 _____, 19____
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____
 20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SO THAT IT MAY BE PROPERLY CLASSIFIED.

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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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 gives 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.