

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

1 PLACE OF DEATH

County Christian

Township Pelf

or

Village

or

City

Registration District No. 181

File No. 13375

Primary Registration District No. 5251

Registered No.

(NO. St. Ward)

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

2 FULL NAME Charles Farmer

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

(Month) V (Day) 1 (Year)

7 AGE

..... yrs. mos. 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)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

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

16 DATE OF DEATH

April 10, 1919
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

February 2, 1919, to April 10, 1919

that I last saw him alive on April 9, 1919

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis of Lungs

(Duration) 2 yrs. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) 15 mos. 15 ds.

(Signed) E. L. Seal M. D.

April 11, 1919 (Address) Republic Mo

*State the 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. 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

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

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.

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) *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 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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH
 County Christian Registration District No. 181 File No. 13375
 Township _____ Primary Registration District No. 2251 Registered No. _____
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME Charles Farmer
 (a) Residence, No. Bellvue, Mo St. _____ Ward _____ Mo _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 15 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb, 22, 1887

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>32</u>		<u>±</u>	<u>18</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer Self - Shellville

9. BIRTHPLACE (CITY OR TOWN) Shellville
 (STATE OR COUNTRY) Tenn.

10. NAME OF FATHER Wm. Farmer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Shellville
 (STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Keatts

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

INFORMANT James Farmer
 (Address) Bellvue, Mo

15. FILED April 19 1919 F.H. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 10 1919

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1919, to April 10, 1919, that I last saw him alive on April 9th, 1919, and that death occurred on the date stated above, at 3 A April 10-19

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY) Influenza
 (duration) yrs. 2 mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: Got sick at Home

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? Physical signs

(Signed) E. L. Beal, M. D.

, 19 (Address) Republic 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

Wm. Olive cemetery Apr 13, 1919

20. UNDERTAKER ADDRESS

W Wallace Bellvue Mo

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

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Revised United States Standard Certificate of Death

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

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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.