

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH
County Stone
Township Flat Creek
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 1096 File No. 16136-a
Primary Registration District No. 6247 Registered No. 6

FULL NAME Bolan Green Wilson

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Jan. 30, 1853
AGE 66 yrs. 2 mos. 24 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country) Cape Fair Mo.

PARENTS
NAME OF FATHER Daniel Wilson
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont know
MAIDEN NAME OF MOTHER Dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Noah Wilson
(ADDRESS) Cape Fair Mo.

Filed 9/1 1919 Wm. H. Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 24, 1919
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from visited him after he died, 1919, that I last saw him alive on _____, 1919, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Cardiac delitiation

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Excessive sexual intercourse
(SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) H. P. Kerr M. D.
4/26 1919 (Address) Cape Fair 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 Wilson Cemetery DATE OF BURIAL April 25, 1919
UNDERTAKER Tom Kerr ADDRESS Cape Fair Mo.

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, 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," "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 Stone Registration District No. 1096 File No. ~~1096~~
 Township Flat Creek Primary Registration District No. 6247 Registered No. 16
 City Cape Fair Mo (No.) St. Ward) (If nonresident give city or town and State)

2. FULL NAME B. Glen Green Wilson
 (a) Residence No. St. Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred 66 yrs. 2 mos. 24 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE Caucasian
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jane Wilson
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 1853
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 66 2 24
 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) Gen. Farming
 (c) Name of employer
 9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cape Fair Mo
 10. NAME OF FATHER Daniel Wilson
 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)

PARENTS

14. INFORMANT Noah Wilson
 (Address) Cape Fair Mo.
 15. FILED 9/11 19 Chas. H. Barnes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 24 19 19
 17. I HEREBY CERTIFY, That I attended deceased from British Spain after he died, to, 19, that I last saw him alive on, 19, and that death occurred, at the date stated above, at 6 P. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac debilitation
19 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Excessive sexual intercourse
 (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH. no DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) N. L. Kerr, M. D.
Apr 26, 1919 (Address) Cape Fair 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 Wilson Cemetery DATE OF BURIAL Apr 25 1919
 20. UNDERTAKER Tom Kerr ADDRESS Cape Fair Mo

Revised United States Standard Certificate of Death

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

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"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.

16136-A