

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

1 PLACE OF DEATH

County Macon  
Township Hudson or Village Macon City Macon (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
Registration District No. 533 File No. 30 30724  
Primary Registration District No. 5913 Registered No. \_\_\_\_\_

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

2 FULL NAME Joseph A Kubin

PERSONAL AND STATISTICAL PARTICULARS

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

6 DATE OF BIRTH Oct 7 869 (Month) (Day) (Year)

7 AGE 49 50 yrs. — 4 mos. — 4 ds. If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Mishonaka Ind

PARENTS  
10 NAME OF FATHER Geo Kubin  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) N.Y.  
12 MAIDEN NAME OF MOTHER Margaret Nichols  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ga

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) August Kubin (Address) Mishonaka Ind

15 Filed 11-10-1919 W. H. Miller Registrar

9 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 11<sup>th</sup> 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from February 16, 1919 to October 11<sup>th</sup>, 1919, that I last saw him alive on October 11<sup>th</sup>, 1919, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH\* was as follows:  
Static Pneumonia  
AM 1919

CONTRIBUTORY Amputation from Rheumatoid (Secondary) Insanity in which he refused to eat (Duration) 1 yrs. 1 mos. 1 ds. (Signed) L. Van Z. Gaudin, M. D. 191 (Address)

\*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 Mishonaka Ind DATE OF BURIAL Oct 14 1919

20 UNDERTAKER Albert Skovron ADDRESS Macon Ind

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.

LOCAL REGISTRAR'S RECORD - DO NOT WRITE

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. .... File No. ....

Village ..... Primary Registration District No. .... Registered No. ....

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 MARRIED WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH	(Month) ..... 1911 (Year)
7 AGE	IF LESS than 1 day ..... hrs. or ..... min. P

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 ..... 1911

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) ..... 1911 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 1911 to ..... 1911 that I last saw h. .... alive on ..... 1911 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH\* was as follows:

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

CONTRIBUTORY (Secondary)

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

(Signed) ..... (Address) ..... 1911 (Address) ..... M. D.

\*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

1911

20 UNDERTAKER

ADDRESS

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

**1. PLACE OF DEATH**

County Macon  
Township Hudson  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 533  
Primary Registration District No. 5713

File No. \_\_\_\_\_  
Registered No. 50  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Joseph A. Kuhn

(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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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 10-20-19 W. H. Miller REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 19 19

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date stated above, at \_\_\_\_\_.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

\_\_\_\_\_ (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) \_\_\_\_\_, M. D.  
, 19 \_\_\_\_\_ (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

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

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

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 helpfulness 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 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.

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