

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.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 5660  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Douglas  
Township Wood  
or  
Village \_\_\_\_\_  
or  
City ~~\_\_\_\_\_~~ \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

Registration District No. 276 File No. 5459  
Primary Registration District No. 3389 Registered No. 1

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

FULL NAME Lewis W Tapp

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED OR DIVORCED <u>married</u> (Write the word)
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DATE OF BIRTH  
Dec 20, 1839  
(Month) (Day) (Year)

AGE  
80 yrs. 2 mos. - 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) \_\_\_\_\_

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

NAME OF FATHER Preston Tapp

BIRTHPLACE OF FATHER (City or town, State or foreign country) not known

MAIDEN NAME OF MOTHER Emily Johnson

BIRTHPLACE OF MOTHER (City or town, State or foreign country) not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(informant) Charles Tapp  
(ADDRESS) Mountain Grove

Filed 3-21 1920 S. M. Tapp  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
Feb 20, 1920  
(Month) (Day) (Year)

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:

200 ft  
Heart Failure  
No Physician present  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
(SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) \_\_\_\_\_ 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.

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 Love Star Farm Cem DATE OF BURIAL Feb 29 1920

UNDERTAKER W J Fenwick ADDRESS Mountain Grove

**PLACE OF DEATH**

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

County \_\_\_\_\_ Township \_\_\_\_\_ File No. \_\_\_\_\_  
 or 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)

**FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

SEX	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
COLOR OR RACE	
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____
AGE	_____ yrs. _____ mos. _____ ds. or _____ yrs. _____ mos. _____ ds. or _____ hrs. _____ min. ?
OCCUPATION	(a) Trade, profession, or business, or establishment in which employed (or employer) (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)

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

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 \_\_\_\_\_.

The CAUSE OF DEATH\* was as follows:

Contributory (SECONDARY) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (Duration)

(Signed) \_\_\_\_\_ (Address) \_\_\_\_\_ M. D. \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, 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 \_\_\_\_\_ 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed \_\_\_\_\_, 191\_\_\_\_ REGISTRAR

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.

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

**1. PLACE OF DEATH**

County Douglas Registration District No. 276 File No. \_\_\_\_\_  
 Township Wood Primary Registration District No. 5389 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lewis W. Japp  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>80</u>	<u>2</u>		

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 2.21.19.20 S. M. Trues  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 20 19 20

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Heart Failure  
fell dead just  
after eating supper  
 CONTRIBUTORY no physician  
 (SECONDARY) but he says if had  
 18. WHERE WAS DISEASE CONTRACTED heart disease  
 IF NOT AT PLACE OF DEATH, none present  
 DID AN OPERATION PRECEDE DEATH no DATE OF January  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) S. M. Trues M.D.  
 , 19 (Address) Prior Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES 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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY; WITH UNFADING INK--THIS IS A PERMANENT RECORD

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SUPPLEMENTARY

# Revised United States Standard Certificate of Death

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

5460

**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," "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, 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.