

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

11270

County Vernon
Township Wasson
or
Village Sheldon
City (NO. St. Ward)

Registration District No. 878 File No.
Primary Registration District No. 14331 Registered No. 20

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

2 FULL NAME

William H Masters

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Feb 5th 1920
(Month) (Day) (Year)

6 DATE OF BIRTH Feb. 22 1889
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 30th 1920, to Feb 5th 1920, that I last saw him alive on Feb 5th 1920, and that death occurred, on the date stated above, at 5-30 P.M.

7 AGE 30 yrs. 11 mos. 17 ds. If LESS than 1 day.....hrs. or.....min.?

The CAUSE OF DEATH* was as follows:
11 A Influenza
198

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

10 (Duration) 10 yrs. 6 mos. 6 ds.

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

CONTRIBUTORY (Secondary) Pneumonia
(Duration) yrs. mos. ds. 5

10 NAME OF FATHER C B Masters

(Signed) Saml. R. Sturwood M. D.
Feb 7th 1920 (Address) Sheldon Mo

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentucky

12 MAIDEN NAME OF MOTHER Ester Sharp

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Quinton Vill Ind.

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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.....

(Informant) C B Masters

(Address) Sheldon Mo

19 PLACE OF BURIAL OR REMOVAL Sheldon Cemetery DATE OF BURIAL Feb -6 1920

15 Filed Feb 8 1920 W. H. D. Applegate Registrar

20 UNDERTAKER C E Lowe ADDRESS Sheldon Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

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

County

Township Registration District No. File No.
 or
 Village Primary Registration District No. Registered No.
 or
 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	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	
6 DATE OF BIRTH	(Month)	(Day)	(Year)
7 AGE	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)		
PARENTS			
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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month), 191..... (Day), 191..... (Year)

17 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:

CONTRIBUTORY (Secondary)

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

*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. State..... 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

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

1. PLACE OF DEATH

County Vernon Registration District No. 878 File No. _____
 Township _____ Primary Registration District No. 4531 Registered No. 20
 City Sheldon St. _____ Ward _____

2. FULL NAME William H. Masters
 (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 M | **4. COLOR OR RACE** W | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** M
(write the word)

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 _____, 19____ **REGISTRAR**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-5 1920

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) Lobar Pneumonia
 (duration) yrs. mos. da. 5

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) Sam R. Harwood, M.D.
 , 19 (Address) Sheldon 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**

20. UNDERTAKER **ADDRESS**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS 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 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

1270
"Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("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.