

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

1144102

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1144102

1. PLACE OF DEATH

County Atchison Registration District No. 19 File No. 1144102
 Township Ray Primary Registration District No. 5095 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Infant of Smith Wagner

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 17 - 1920

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Atchison Co Mo
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Smith Wagner
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Atchison Mo
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Lydia Lindale
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Atchison Co Mo
 (STATE OR COUNTRY) _____

14. INFORMANT Smith Wagner
 (Address) Rock Port Mo

15. FILED 11-7-20 O McChaulin
m.g.c. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 22nd 1920
 17. I HEREBY CERTIFY, That I attended deceased from Feb. 21st 1920, to Feb. 22nd 1920, (that I last saw him alive on Feb. 22nd 1920, and that death occurred, on the date stated above, at 4 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Too weak and poorly nourished to survive.

CONTRIBUTORY (SECONDARY) ✓
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) William R. Strickland, M. D.
7/1, 1920 (Address) Rockport, 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 Smith Cemetery DATE OF BURIAL Mar 22 1920

20. UNDERTAKER W. E. Hebrun ADDRESS Rockport Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be stated EXACTLY. Every item of information should be carefully classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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*, *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 child-birth 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.

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

1. PLACE OF DEATH

County Johnson Registration District No. 19 File No. _____
 Township Clark Primary Registration District No. 5025 Registered No. _____
 City _____ St. _____ Ward _____

2. FULL NAME

(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE/MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 17, 20</u>		
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 _____		
BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____		

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 22, 1921

17. I HEREBY CERTIFY, That I attended deceased from Mar 17, 1921 to Mar 22, 1921 that I last saw him alive on Mar 22, 1921, and that death occurred on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Perinatal Death
Baby not sufficiently developed to live.
 (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) Willeugh R. Strickland, M.D.
Feb 16, 1921 (Address) Keosauqua, 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 _____

PARENTS

SUPPLEMENTARY

1-1-20 Q Mc Chamberlain
mgc
 REGISTRAR

INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

--THIS IS THE STYLE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 4. Properly classified. Exact statement of OCCUPATION is very important.
 5. AGE should be stated EXACTLY. PHYSICIANS should state properly classified.

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

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"Typhoid pneumonia"); *Lobar pneumonia* ("Pneumonia," unqualified, *Tuberculosis of lungs, meninges, peritoneum, 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," "Anomia" (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.)

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