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 Jancy

Township Oliver

or

Village

or

City (NO. St.; Ward)

Registration District No. 860

Primary Registration District No. 6130

File No. ~~217~~

Registered No. 15319-a

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

FULL NAME X Thomson

PERSONAL AND STATISTICAL PARTICULARS

SEX: bay

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): +

DATE OF BIRTH: Dec (Month) 9 (Day), 1919 (Year)

AGE: 1 yrs. 2 mos. 27 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): +

BIRTHPLACE (City or town, State or foreign country): Pinetop mo

PARENTS

NAME OF FATHER: M. H. thomson

BIRTHPLACE OF FATHER (City or town, State or foreign country): mo

MAIDEN NAME OF MOTHER: mary noland

BIRTHPLACE OF MOTHER (City or town, State or foreign country): mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J G Cox

(ADDRESS) omaho ark

Filed 8-5, 1920, R. B. Kite

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: mar (Month) 5 (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 20, 1920, to Mar 5, 1920, that I last saw him alive on feb 20, 1920, and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Indigestion and Disease of the stomache

(Duration) 1 yrs. 2 mos. ___ ds.

Contributory (SECONDARY)

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

(Signed) Dr J G Cox M. D.

___, 191___ (Address) omaho ark

*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: omaho ark

DATE OF BURIAL: mar 6, 1920

UNDERTAKER

ADDRESS

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, peritonaeum,* 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 *septichaemia,*" "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.)

HUGH STEPHENS, JEFFERSON CITY.

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

1. PLACE OF DEATH
County Laney
Township Oliver
City ..... (No. ..... St. ..... Ward)
Registration District No. 860
Primary Registration District No. 6130
File No. .....
Registered No. 217

2. FULL NAME Infant Thomson
(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 W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-9-1919
7. AGE Years 1 Months 2 Days 27 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Pinetop Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER M A Thomson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Mary Noland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT T. G. Cox
(Address) Omaha Ark
15. FILED 8-5, 1920 R. B. Kite REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5 1920
17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1920, to Mar 5, 1920 that I last saw him alive on Feb 20, 1920, and that death occurred on the date stated above, at ..... m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Indigestion and disease of the stomach
(duration) ..... yrs. 2 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) T. G. Cox, M. D
, 19 (Address) Omaha Ark

*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 Omaha Ark
DATE OF BURIAL Mar. 6 1920
20. UNDERTAKER T. G. Cox
ADDRESS Omaha Ark

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Revised United States Standard Certificate of Death

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

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15319-a

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.