

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

32352

1. PLACE OF DEATH St Clair
 County Appleton Registration District No. 761 File No.
 Township Appleton City Mo Primary Registration District No. 4456 Registered No.
 City Appleton City Mo St. _____ Ward _____

2. FULL NAME William Rollin Cochran
 (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

MEDICAL CERTIFICATE OF DEATH

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) Aug 4 1919

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24 1920
 17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920 to Oct 24 1920, and that I last saw him alive on Oct 24 1920, and that death occurred, on the date stated above, at 2 P.M.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 2 20

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Burn

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

(duration) yrs. mos. ds. 2 ds.

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

9. BIRTHPLACE (CITY OR TOWN) Appleton City Mo
 (STATE OR COUNTRY)

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

10. NAME OF FATHER Earl C Cochran

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Johnson County Mo
 (STATE OR COUNTRY)

20. WAS THERE AN AUTOPSY? No.

12. MAIDEN NAME OF MOTHER Mary Resby

WHAT TEST CONFIRMED DIAGNOSIS (Signed) R. G. Smith M. D.
 (Address) Appleton City

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Reese County Mo
 (STATE OR COUNTRY)

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT John Resby
 (Address) Appleton City Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Appleton City Mo Oct 25 1920

15. FILED Oct 25 1920 W. Collins M.D. REGISTRAR

20. UNDERTAKER ADDRESS
A. J. Johnson Appleton City Mo

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*, *Composer*, *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 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
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 Township _____ Primary Registration District No. 4456 Registered No. _____
 City Appleton (No. _____) St. _____ Ward _____

2. FULL NAME William Rollin Cochran
 (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>S</u>
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)		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-24 19 20

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: Burned accidentally over turning a pot of hot coffee

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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) R. Smith M. D.
Jan 1, 1921 (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

SUPPLEMENTARY

14. INFORMANT (Address) _____

15. FILED Jan 10 1921 no. Clin M.D. REGISTRAR

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

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"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.)

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