

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

1 PLACE OF DEATH

County Shelby  
Township Sack River  
or  
Village  
or  
City

Registration District No. 831 File No. 3001 ✓  
Primary Registration District No. 6092 Registered No. 2  
(NO. St. Ward)

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

2 FULL NAME

George W. Phillips

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16 DATE OF DEATH Jan 19, 1921  
(Month) (Day) (Year)

6 DATE OF BIRTH Aug 14, 1830  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from X, 191, to X, 191, that I last saw h. X alive on X, 191, and that death occurred, on the date stated above, at 5:00 a. m.

7 AGE 90 yrs. 5 mos. 5 ds. If LESS than 1 day... hrs. or... min.?

The CAUSE OF DEATH\* was as follows:  
Found dead, in bed  
no inquest  
2 1/2 (Duration) yrs. mos. ds.

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

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Wm Carson M. D. Jan 19, 1921 (Address) Shelbyville, Mo

9 BIRTHPLACE (City or town, State or foreign country) Ill.

\*State the Disease Causing Death, or, in deaths 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. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PARENTS 10 NAME OF FATHER Thos. Phillips  
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) no record  
12 MAIDEN NAME OF MOTHER no record  
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) no record

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Eva Coddrey (Address) Shelbyville, Mo

19 PLACE OF BURIAL OR REMOVAL Shelbyville, Mo DATE OF BURIAL Jan 20, 1921

15 Filed Jan 19, 1921 W. Carson Registrar

20 UNDERTAKER W. Thompson ADDRESS Shelbyville, Mo

# 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  
County .....

Township..... Registration District No. .... File No. ....  
or  
Village ..... Primary Registration District No. .... Registered No. ....  
or  
City ..... (NO....., St.:..... Ward) .....

2 FULL NAME .....

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

### 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	..... yrs. .... mos. .... ds.	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) .....

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

10 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.

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

(Address)..... M. D.

\*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. 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 Shelby Registration District No. 83/1 File No. \_\_\_\_\_  
 Township Wagon Primary Registration District No. 6092 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME George W. Phillips  
 (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 W  
(Divorced 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 Myopora Goddard  
 (Address) Shelbyville Mo

15. FILE NO. 28-21 W-6092 REGISTRY \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 19 1920

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Stand dead - cause of death unknown  
 (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? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) Wm. Coarson M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) Shelbyville

\*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 W. Thompson DATE OF BURIAL Jan 20 1920

20. UNDERTAKER Shelbyville Mo ADDRESS \_\_\_\_\_

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

REGISTRARS SHALL NOT 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.]

**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 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.