

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

29585

399

1. PLACE OF DEATH  
 County Jackson Registration District No. 112 File No. \_\_\_\_\_  
 Township Year Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 City Classey (No. 72 C Agel 112 10) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Unknown Infant  
 (a) Residence. No. 72 C Agel 112 10 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. 1 mos. 6 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) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3, 1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 | 6 | \_\_\_\_\_

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Infant  
 (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) Not known

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Not known

14. INFORMANT Reverend Clerk (Address) 72 C Agel 112 10

15. FILED 11/30 1921 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 9 1921

17. I HEREBY CERTIFY, That I attended deceased from Oct 3, 1921, to Nov 9, 1921 that I last saw him alive on Nov 9, 1921, and that death occurred, on the date stated above, at 2:44 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Malnutrition  
158  
 \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Unknown  
 \_\_\_\_\_ (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) W. H. Hux, M. D.  
11/10 1921 (Address) 72 C Agel 112 10

\*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 Leeds DATE OF BURIAL 12/1/21

20. UNDERTAKER W. Bergman ADDRESS 100 mo

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

# United States Standard Certificate of Death

U. S. Census and American Public Health Association.)

"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 neoplasma); *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.

19. FILED

15.

(Address)

INFORMANT

14.

(STATE OR COUNTY)

13. BIRTHPLACE OF

12. MAIDEN NAME

(STATE OR COUNTY)

11. BIRTHPLACE OF

10. NAME OF FATHER

(STATE OR COUNTRY)

9. BIRTHPLACE (CITY OR

(c) Name of employer which employed (or established) business, or establishment of

(b) General nature of particular kind of work

(a) Trade, profession, occupation of DE

8. OCCUPATION OF DE

7. AGE

YEARS

6. DATE OF BIRTH (MONTH

5A. IF MARRIED, WIDOWED, OR HUSBAND OR WIFE OF

4. SEX

PERSONAL

(a) Residence No. (Usual place of residence in city)

2. FULL NAME

City

Township

County

1. PLACE OF DEATH

of Occupation.—Precise statement of very important, so that the relative of various pursuits can be known. The is to each and every person, irrespec- or many occupations a single word or t line will be sufficient, e. g., *Farmer* or *ician, Compositor, Architect, Locomo- civil Engineer, Stationary Fireman, etc.* ases, especially in industrial employ- b necessary to know (a) the kind of work e nature of the business or industry, in additional line is provided for the t; it should be used only when needed. p) *Spinner, (b) Cotton mill; (a) Sales- ry; (a) Foreman, (b) Automobile fac- erial worked on may form part of the nt. Never return "Laborer," "Fore- ger," "Dealer," etc., without more ation, as Day laborer, Farm laborer, mine, etc. Women at home, who are duties of the household only (not paid ho receive a definite salary), may be usewife, Housework or At home, and ainfully employed, as At school or At ould be taken to report specifically s of persons engaged in domestic es, as Servant, Cook, Housemaid, etc. on has been changed or given up on DISEASE CAUSING DEATH, state occu- nning of illness. If retired from busi- may be indicated thus: *Farmer (re- For persons who have no occupation e None.**

t of Cause of Death.—Name, first, AUSING DEATH (the primary affection ) time and causation), using always the l term for the same disease. Examples: *fever* (the only definite synonym is erebrospinal meningitis"); *Diphtheria* "Croup"); *Typhoid fever* (never report