

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

5615

1. PLACE OF DEATH

County Monroe Registration District No. 581 File No. _____
 Township _____ Primary Registration District No. 1343- Registered No. 8
 City Monroe (No. _____) St. _____ Ward _____

2. FULL NAME Herbert Lewis Williams

(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 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) Feb'y 10th 1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
7

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) Monroe City
 (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Levy Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Monroe City Mo

12. MAIDEN NAME OF MOTHER Luella Belle Dixon

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Monroe City Mo

14. INFORMANT Levy Williams
 (Address) Monroe City Mo.

15. FILED 2/18 1922 O. W. Wilson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb'y 17th 1922

17. I HEREBY CERTIFY, That attended deceased from Feb'y 10th 1922 to Feb'y 17th 1922, that I last saw him alive on Feb'y 17th 1922, and that death occurred, on the date stated above, at 2nd name

THE CAUSE OF DEATH* WAS AS FOLLOWS:

congestion of Brain

CONTRIBUTORY convulsions
 (SECONDARY) (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

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

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Geo. L. Turner, M. D.
2/18, 1922 (Address) Monroe City 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 St. Judas Cemetery DATE OF BURIAL Feb'y 18th 1922

20. UNDERTAKER Wilson + Son Monroe City Mo. ADDRESS _____

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.

PERMANENT
FACT

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 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.

1 PLACE OF DEATH

County Monroe

Township _____

or _____

Village _____

or _____

City Monroe

(No. _____)

St.; _____

Ward _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State of _____

Registered No. _____

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

2 FULL NAME Herbert Lewis Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE N5 SINGLE, MARRIED, WIDOWED, OR DIVORCED S
(Write the word)

6 DATE OF BIRTH _____

(Month) _____

(Day) _____

1

(Year) _____

7 AGE _____

If LESS than _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 17 - 1922

(Month) _____

(Day) _____

(Year) _____

17 I HEREBY CERTIFY That I attended deceased from _____

191 _____

191 _____

that I last saw him _____ alive on _____, 191 _____

occurred, on the date stated above, at _____ m.

DEATH* was as follows:

gestion of brain

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

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

M. D.

1 (Address) _____

CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, ETC.)

_____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

tracted,

18 OR REMOVAL _____

DATE OF BURIAL _____

191 _____

ADDRESS _____

IS A PERMANENT RECORD
Should be stated EXACTLY. PHYSICIANS should state classified. Exact statement of OCCUPATION is very

Date _____ Patients Name _____

Address _____

Monroe City Mo. June 4th 1923
 In reference to the within death certificate
 normal birth, was not delivered with
 instruments. The child was born
 appeared healthy and vigorous. No indication
 of violence. Was well up to 24 hours
 before death. Had convulsions continuously
 for 24 hours.

Geo L. Turner M. D.

TAKE THIS TO
 Spalding & Noel Pharmacy
 PHONE NO. 46
 MONROE CITY, MISSOURI

Reg. No. _____ Address _____

REGISTRAR

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