

29 1926

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

Do not use this space.

5861-a

## 1. PLACE OF DEATH

County Platte  
Township Carroll

Registration District No. 694  
Primary Registration District No. 5924

File No. ....  
Registered No. 18  
St. .... Ward)

City (No. ....)  
NAME Hugh Chance  
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

SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) last known

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>47</u>	<u>12</u>	<u>-</u>	<u>-</u>	<u>-</u>

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labour  
(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) Last known

## 10. NAME OF FATHER

Last known

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) -

## 12. MAIDEN NAME OF MOTHER

Last known

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) -

## 14.

INFORMANT No informant  
(Address) .....

## 15.

FILED Body found in well after  
REGISTRAR

having been missing some 4 years  
Sept. 1-1926 - May 93, Knight

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) not known 19 .....

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

## THE CAUSE OF DEATH WAS AS FOLLOWS:

found in well - April 24-26. Homicide  
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## CONTRIBUTORY (SECONDARY)

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18. DID AN OPERATION PRECEDE DEATH..... DATE OF .....

18. WAS THERE AN AUTOPSY.....

18. WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. N. Bull, Coroner

April 24 1926 (Address) Weston, Iowa

\*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

## 20. UNDERTAKER

J. F. Rollins

## ADDRESS

Platte City, Mo.

# Review of 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 on the first line will be sufficient, e. g., *Farmer, Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*. But in many cases, especially in industrial enterprises, 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 necessary. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Man*, (b) *Grocery*; (a) *Foreman*, (b) *Automotive*. The material worked on may form part of the second statement. Never return "Laborer," "man," "Manager," "Dealer," etc., without precise specification, as *Day laborer, Farm Laborer—Coal mine*, etc. Women at home, 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. terminal conditions.

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  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Platte

Registration District No. 696

File No. ....

Township Carnell

Primary Registration District No. 5-924

Registered No. 15

(City) ..... (No. ....) ..... St. .... Ward)

**DECEASED NAME** Hugh Chance

(a) Residence No. .... St. .... Ward. .... (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) w

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)

PARENTS

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 (Address)

15. FILED Nov-9-26 Mary B. Knight REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb - 1922

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

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

..... (duration) ..... yrs. .... mos. .... da.

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)....., M. D. , 19 (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

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED

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Death occurred the latter part of Feb. 1922  
at the house one a.m for work and never returned.  
no one remembers the date, as he was working  
a farmer and had no home. Just where ever he  
led. and sometimes he would leave a place and  
tell any one he was leaving and maby be weeks.  
e they would hear from him. This is all information  
possibly, find out. I understand there are people

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This case as they think the man was  
then thrown in well.

Very truly,

Mary B. Knight:

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THE STATE BOARD OF HEALTH  
OF MISSOURI  
CITY OF JEFFERSON

JAMES STEWART, M. D., SECRETARY  
AND STATE HEALTH COMMISSIONER  
IRL BROWN KRAUSE, M. D., ASSISTANT  
HEALTH COMMISSIONER



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ADDRESS ALL COMMUNICATIONS  
TO THE STATE BOARD OF HEALTH