

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

8120

1. PLACE OF DEATH

County Daveiss Registration District No. 249 File No.
 Township Washington Primary Registration District No. 5847 Registered No. 5
 City (No.) St. F Ward)

2. FULL NAME Charles D. Murtline Lake

(a) Residence. No. St. Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maggie May Lake

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12th 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 6 21

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer 126
 (b) General nature of industry, business, or establishment in which employed (or employer) 107
 (c) Name of employer 819

9. BIRTHPLACE (CITY OR TOWN) Bone Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Thos Lake

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sarah Howard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

14. INFORMANT Mrs. James Dawell
 (Address) Union City Mo

15. FILED 3/6 22 19 22 J. A. Burtch
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5th 1922

17. I HEREBY CERTIFY, That I attended deceased from Mar 2nd 1922 to Mar 5th 1922, that I last saw him alive on Mar 5th 1922, and that death occurred, on the date stated above, at 12:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Sepsisemia with
Pneumonia
 (duration) yrs. mos. 12 ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IS NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 22/22

WHAT TEST CONFIRMED DIAGNOSIS? operated on & bacteriologic

(Signed) T. M. Waters M.D. M. D.
 , 19 (Address) Coffey 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 Galuae Cemetery DATE OF BURIAL Mar 6 1922

20. UNDERTAKER W. D. Haines ADDRESS Galuae City

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.

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 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

County Davies
Township Washington 249
or
Village _____ 5347
or
City _____ (No. _____ St.; _____ Ward)

State of _____

Registered No. 8120

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

2 FULL NAME Charles Franklin Lake

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

M6 DATE OF DEATH Mar 5 - 1932

(Month) (Day) (Year)

6 DATE OF BIRTH _____

(Month) (Day) (Year)

7 AGE _____

If LESS than 1 day, _____ hrs. or _____ min. ?

_____ yrs. _____ mos. _____ ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) Operation

9 BIRTHPLACE (State or country) _____

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed 3/6 1932J. A. Burt
REGISTRAR

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:

Septicemia with pneumonia
Gall stones
Other pneumonia

Contributory (SECONDARY) _____

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

(Signed) _____, M. D.

_____, 191____ (Address) _____

*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 _____

19 PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

20 UNDERTAKER _____

ADDRESS _____

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