

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

9367

**1. PLACE OF DEATH**

County Macon Registration District No. 529 File No. ....  
Township Morrow Primary Registration District No. 5706 Registered No. ....  
City ..... (No. ....) St. .... Ward)

**2. FULL NAME**

Paul W Perrin  
(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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 16 7 7  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 16 7 7  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work farmer  
(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) Macon Pa  
10. NAME OF FATHER C W Perrin  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Macon Pa  
12. MAIDEN NAME OF MOTHER Elisopouch  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Randall Pa

14. INFORMANT (Address) P. W. Perrin Callow mo  
15. FILED 3-25-22 J. L. Trippe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 19 1922  
17. I HEREBY CERTIFY, That I attended deceased from Mar 16 1922 to Mar 16 1922  
that I last saw him alive on Mar 14 1922, and that death occurred, on the date stated above, at 7 4. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis  
3 2 22

CONTRIBUTOR (SECONDARY) None (duration) 2 yrs. 4 mos. 6 ds.  
3 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home  
IF NOT AT PLACE OF DEATH, DATE OF 1  
DID AN OPERATION PRECEDE DEATH? No  
WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Physical  
(Signed) Dr. W. C. Atkins, M. D.  
3-18 1922 (Address) Callow, 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 DATE OF BURIAL  
Parson 3/18 1922  
20. UNDERTAKER ADDRESS  
G. C. Perry Callow

# 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.

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

**1. PLACE OF DEATH**

County Macon  
Township Narrow  
City (No. St. Ward)

Registration District No. 529  
Primary Registration District No. 5706

File No. ....  
Registered No. ....

**2. FULL NAME**

Pure W. Perrin

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 17 1922

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
16 7 7

**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 .....

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

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

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

WAS THERE AN AUTOPSY?.....

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

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) F. W. Allen, M. D.

12. MAIDEN NAME OF MOTHER

, 19 (Address) Ballao mo.

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

\*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.)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

15. FILED 3/25 1922 F. L. Trippe REGISTRAR

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH in plain terms, so that it may be properly construed. Exact statement of OCCURRENCE of DEATH.

SUPPLEMENTARY

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

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