

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

13256

1. PLACE OF DEATH
 County Franklin Registration District No. 943 File No. _____
 Township Union Primary Registration District No. 5315 Registered No. _____
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME George Morris
 (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) married

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, _____hra. or _____min.
24 X 2 ^ 1 *

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber X
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ X
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Chicago X
 (STATE OR COUNTRY) _____ X

10. NAME OF FATHER John B Morris X

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jackson X
 (STATE OR COUNTRY) Mo Ohio ^

12. MAIDEN NAME OF MOTHER Woods X

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ X
 (STATE OR COUNTRY) Frankford Mo Mo ^

14. INFORMANT Woods X
 (Address) _____ X

15. FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/7/22 1922
 17. I HEREBY CERTIFY That I attended deceased from out
15 1921 to May 7 1922
 that I last saw h. a. v. a. alive on May 3 1922 and that death occurred, on the date stated above, at 10 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lung

CONTRIBUTORY (SECONDARY) 31
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED St Louis Mo
 IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Genl Postm
Dr. P. P. P. M. D.
 (Signed) _____ (Address) Shelville 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 Woods Cemetery DATE OF BURIAL 5/9 1922

20. UNDERTAKER L J Jones ADDRESS Shelville 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.

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 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.

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

1. PLACE OF DEATH

County Crawford
 Township Union
 City (No.) St. Ward)

Registration District No. 943
 Primary Registration District No. 5315

File No. 6
 Registered No. 6

2. FULL NAME George Morris

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

PERSONAL AND STATISTICAL PARTICULARS

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

Male White Married

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

Married

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 2 1

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer Patrol No. 1

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

Coal Station Mo

10. NAME OF FATHER

John B. Morris

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

Armo
Union Mo

12. MAIDEN NAME OF MOTHER

Hester Wood

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

Crawford Mo

14. INFORMANT (Address)

John B. Morris
Union Mo

15. FILED

July 11 1922
R. F. Vaughan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/7 1922

17. I HEREBY CERTIFY, That I attended deceased from June 1 1922, to May 7 1922, that I last saw him alive on May 7 1922, and that death occurred on the date stated above, at 11 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

tuberculosis of lung

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: St. Louis

DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. J. Parker M. D.
 19 (Address) St. Louis

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Cross Country

DATE OF BURIAL

5/7 1922

20. UNDERTAKER

R. F. James

ADDRESS

St. Louis

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

PHYSICIAN TO BE STATED EXACTLY AS PRESCRIBED BY REGISTRATION IS COMPLETED AS PRESCRIBED BY EXACT STATEMENT OF CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY RECORDED. REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATE. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.

RECEIVED SUPPLEMENTARY

Revised United States Standard Certificate of Death

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

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