

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

2222

1. PLACE OF DEATH

County Knox Registration District No. 441 File No. _____
 Township Liberty Primary Registration District No. 6243 Registered No. 19
 City _____ St. _____ Ward _____

2. FULL NAME

Paul G Walters

(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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 14 - 1922

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
1 9-4

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) (STATE OR COUNTRY) Knox, Co Mo

10. NAME OF FATHER Will Walter

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

12. MAIDEN NAME OF MOTHER Mary Huiatt

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

14. INFORMANT (Address) William Walters
Edina Mo

15. FILED 71 1922 Les Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 8 1922

17. I HEREBY CERTIFY, That I attended deceased from June 27 1922 to July 8 1922
 that I last saw him alive on July 6 1922 and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Whooping cough
& sequelae of lung
 (duration) yrs. ____ mos. ____ ds.

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

18. WHERE WAS DISEASE CONTRAICTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Les Brown, M. D.
4/8, 1922 (Address) Edina 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 Joseph Cemetery DATE OF BURIAL July 9 1922

20. UNDERTAKER Kriegshauser Bros ADDRESS Edina Mo

K. E.—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* ("Pneumonia," unqualified); *Tuberculosis of lungs, meninges*, etc.; *Carcinoma, Sarcoma*, etc., of gin; "Cancer" is less definite; avoid use for malignant neoplasma); *Measles*; *Chronic valvular heart disease*; *Chronic nephritis*, etc. The contributory (secondary) affection need not be stated. Example: *Measles* (disease 29 ds.; *Bronchopneumonia* (second). Never report mere symptoms or terms such as "Asthenia," "Anemia" (metabolic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus"), "Shock," "Uremia," "Weakness," etc. A definite disease can be ascertained. Always qualify all diseases resulting in birth or miscarriage, as "PUERPERAL," "PUERPERAL peritonitis," etc. State which surgical operation was used. VIOLENT DEATHS state MEANS OF INJURY as ACCIDENTAL, SUICIDAL, OR HOMICIDE, probably such, if impossible to determine. Examples: *Accidental drowning*; *Way train—accident*; *Revolver wound—homicide*; *Poisoned by carbolic acid*—p The nature of the injury, as fracture, and its consequences (e. g., *sepsis, tetanus*), should be stated under the head of "Contributory." Refer to statement of cause of death to the Committee on Nomenclature of Diseases, American Medical Association.)

NOTE.—Individual offices may add to above terms and refuse to accept certificates. Thus the form in use in New York City state will be returned for additional information on the following diseases, without explanation, of death: *Abortion, cellulitis, childbirth, cholera, gangrene, gastritis, erysipelas, meningitis, necrosis, peritonitis, phlebitis, pyemia, sepsis*. But general adoption of the minimum list suggests vast improvement, and its scope can be extended.

ADDITIONAL SPACE FOR FURTHER STATEMENT BY PHYSICIAN.