

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

1. PLACE OF DEATH

County Jefferson Registration District No. 420 File No. 1594
 Township De Soto Mo Primary Registration District No. 3027 Registered No. 27
 City De Soto Mo St. _____ Ward _____

2. FULL NAME Ann named

(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) X

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
0 0 0 2 hrs.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) De Soto Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Charles Sprangler

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

12. MAIDEN NAME OF MOTHER Ethel Cox

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

14. INFORMANT Claude Sprangler
 (Address) De Soto Mo

15. FILED 7/11 23 19 23 D.H. Pugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1923

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on Jan 11, 1923, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Delivery
No Cause (duration) _____ yrs. _____ mos. _____ ds.

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

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

DID AN OPERATION PRECEDE DEATH? X DATE OF _____

WAS THERE AN AUTOPSY? X

WHAT TEST CONFIRMED DIAGNOSIS? X
 (Signed) George W. Adams, M. D.
7/11, 1923 (Address) De Soto 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 De Soto Mo DATE OF BURIAL Jan 12 1923

20. UNDERTAKER Family ADDRESS De Soto Mo

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 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.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH

County Jefferson State MISSOURI 420 Registered No. 103
 Township _____ or Village 3022 _____ of _____
 City De Soto No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME

Sprangler (Unnamed Infant)

(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

MEDICAL CERTIFICATE OF DEATH

3 SEX m **4 COLOR OR RACE** w **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Ø

6 DATE OF DEATH (month, day, and year) Jan 1 1923

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

HEREBY CERTIFY, that I attended deceased from 10/21 1923 to 10/21 1923

6 DATE OF BIRTH (month, day, and year) 10-31-1922

that I last saw he alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

7 AGE Years 0 Months 0 Days 0 If LESS than day, hrs. or min.

The CAUSE OF DEATH* was as follows:

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 _____

Perinatal
Still Born

9 BIRTHPLACE (city or town) De Soto Mo
 (State or country)

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

10 NAME OF FATHER Ray Sprangler

18 Where was disease contracted _____
 If not at place of death? _____

11 BIRTHPLACE OF FATHER (city or town) De Soto Mo
 (State or country)

Did an operation precede death? _____ Date of _____

12 MAIDEN NAME OF MOTHER Ethel Beum

Was there an autopsy? _____

13 BIRTHPLACE OF MOTHER (city or town) Hopewell Mo
 (State or country)

What test confirmed diagnosis? _____

14 Informant Ray Sprangler
 (Address) De Soto Mo

(Signed) Chas E Fallet, M. D.

15 Filed 10/31, 19 23 Dr. Sprangler
 REGISTRAR

, 19 (Address) De Soto Mo

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instructions on back of certificate.

SUPPLEMENTAL

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BY PHYSICIAN.