

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
County Polk
Township Jefferson
or Village
or City

Registration District No. 709 File No. 6160
Primary Registration District No. 5938 Registered No. 12
(NO. _____ St. _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Baby Hogan

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Feb 12, 1923
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. 8 ds. IF LESS than
1 day, _____ hrs.
or _____ min.?

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

BIRTHPLACE
(City or town, State or foreign country) Mo

PARENTS
NAME OF FATHER Robert Hogan
BIRTHPLACE OF FATHER Ill
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Bertha Marie Meinecke
BIRTHPLACE OF MOTHER Ill
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R E Hogan
(ADDRESS) Glennington Mo

Filed Feb 25, 1923 De Meier
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 20, 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 2, 1923, to Feb 13, 1923, that I last saw him alive on Feb 13, 1923, and that death occurred, on the date stated above, at 10 9 m. The CAUSE OF DEATH* was as follows:

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

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

(Signed) De Meier M. D.
(Address) Glennington, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

PLACE OF BURIAL OR REMOVAL Rondo DATE OF BURIAL Feb 20, 1923

UNDERTAKER _____ ADDRESS _____

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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Polk State MISSOURI. 709 Registered No. _____
 Township Jefferson or Village 5938 or _____
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hogan (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 ⊗
(writes the word)

16 DATE OF DEATH (month, day, and year) Feb 20 1923

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

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

6 DATE OF BIRTH (month, day, and year) _____

that I last saw h_____ alive on _____, 19____,

7 AGE Years _____ Months _____ Days _____ if less than 1 day, hrs. or min.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Convulsions

8 OCCUPATION OF DECEASED

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

do not know (duration) _____ yrs. _____ mos. _____ ds.

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

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

(c) Name of employer _____

18 Where was disease contracted _____

9 BIRTHPLACE (city or town) _____ (State or country) _____

If not at place of death? _____

Did an operation precede death? _____ Date of _____

10 NAME OF FATHER _____

Was there an autopsy? _____

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____

What test confirmed diagnosis? _____

12 MAIDEN NAME OF MOTHER _____

(Signed) _____, M. D.
 _____, 19 (Address) _____

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 Feb 25, 1923 D. Neumann REGISTRAR

20 UNDERTAKER _____ ADDRESS _____

SUPPLEMENTAL

10

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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

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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.

11-3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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