

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

*gum*  
10083

1. PLACE OF DEATH  
 County Shoep Registration District No. 677 File No. 1  
 Township Reela Primary Registration District No. 4403 Registered No. 16  
 City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Willard F. Faulkner  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_ (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) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Nancy Faulkner  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 19 1861  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
61 7 19  
 8. OCCUPATION OF DECEASED Druggist  
 (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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1923  
 17. I HEREBY CERTIFY, That I attended deceased from May 30, 1921, to Mar 7, 1923, that I last saw him alive on Mar 6, 1923, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Myocardites  
 (duration) yrs. 20 mos. da.  
 CONTRIBUTORY (SECONDARY)  
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY?  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) W. S. South, M. D.

12. MAIDEN NAME OF MOTHER Margaret Ella Guy 3/8, 1923 (Address) Reela 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.)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Missouri  
 10. NAME OF FATHER R. F. Faulkner  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) OK

14. INFORMANT F. G. Faulkner  
 (Address) Reela Mo  
 15. FILED 3/9, 1923 Joe F. Ayers REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Reela Cemetery DATE OF BURIAL 3/9 1923  
 20. UNDERTAKER H. W. Moore ADDRESS Reela Mo

# 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 Phelps State MISSOURI. Registered No. 677  
 Township \_\_\_\_\_ or Village 4403 or \_\_\_\_\_  
 City Rolls No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Millard F. Faulkner  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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.  
(If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16 DATE OF DEATH (month, day, and year) Mar 7 1923

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

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,

6 DATE OF BIRTH (month, day, and year) \_\_\_\_\_

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

7 AGE Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
IF LESS than day \_\_\_\_\_ hr \_\_\_\_\_ min \_\_\_\_\_

The CAUSE OF DEATH\* was as follows:

myocarditis acute

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 \_\_\_\_\_

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_

9 BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

18 Where was disease contracted (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 May 23, 1923 Jos. F. Myers REGISTRAR  
 11-2184

20 UNDERTAKER ADDRESS

\_\_\_\_\_

SUPPLEMENT

TION is very important. See instructions on back of certificate.

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