

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. See instructions on back of Certificate.

1. PLACE OF DEATH.

County Barry  
 Township Ash #1  
 Inc. Town \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St; \_\_\_\_\_ Ward)

STATE OF ARKANSAS *Missouri*  
 STATE BOARD OF HEALTH  
 Bureau of Vital Statistics  
 CERTIFICATE OF DEATH **11874**

Registration District No. 37 File No. 56  
 Primary Registration District No. 5253 6241 Registered No. 85

2 FULL NAME Elmer Vanzandt

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 (Write the word)

6. DATE OF BIRTH 1/9/04  
 Month Day Year

7. AGE 19 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min?

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

9. BIRTHPLACE (State or Country) Barry Co Mo

PARENTS

10. NAME OF FATHER Allie Vanzandt

11. BIRTHPLACE OF FATHER (State or Country) Barry Co Mo

12. MAIDEN NAME OF MOTHER Francis Heather

13. BIRTHPLACE OF MOTHER (State or Country) Barry Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Sid Fletcher  
 (Address) Tarfield Ark R7D2

15. Filed 4-6 1922 W R R Smith REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1, 1923  
 Month Day Year

17. I HEREBY CERTIFY That I attended the deceased from Feb. 13, 1923, to March 30, 1923, that I last saw him alive on March 30 1923, and that death occurred on the date stated above, at 4 Pm.

The CAUSE OF DEATH \* was as follows:  
General Tuberculosis

23A  
37  
 Duration yrs. 6 mos. ds.  
 Contributory SECONDARY  
 Duration yrs. \_\_\_\_\_ mos. ds.

Signed R. R. McHenry, M. D.  
April 1, 1923 Address Seligman Mo.

\*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. 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 \_\_\_\_\_

19. PLACE OF BURIAL OR REMOVAL Hickman Cemetery DATE OF REMOVAL 4/21/23

20. UNDERTAKER Seligman Hdw Co ADDRESS Seligman Mo

**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, peritonacum*, 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 of 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 DEATH state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic 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 statements 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 Barry 37 State MISSOURI Registered No. 85  
 Township ash 624 or Village \_\_\_\_\_ or \_\_\_\_\_  
 City \_\_\_\_\_ No. \_\_\_\_\_ St., \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elmer Vanzandt  
 (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 m 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED 8  
(write the word)  
 5a If married, widowed, or divorced HUSBAND of (or) WIFE of \_\_\_\_\_  
 6 DATE OF BIRTH (month, day, and year) 1904   
 7 AGE Years 19 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day, --- hrs. or --- min.

8 OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Barry Co  
 (State or country) mo

10 NAME OF FATHER Allie Vanzandt  
 (State or country) Barry Co mo  
 11 BIRTHPLACE OF FATHER (city or town) \_\_\_\_\_  
 (State or country) \_\_\_\_\_  
 12 MAIDEN NAME OF MOTHER Theresa Weathers  
 13 BIRTHPLACE OF MOTHER (city or town) \_\_\_\_\_  
 (State or country) Barry Co mo

14 Informant Sid Fletcher  
 (Address) Garfield Park

15 Filed 4/6 19 23 Dr R R Smith  
 11-2184 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH (month, day, and year) April 1 1923  
 17 I HEREBY CERTIFY, That I attended deceased from 2/13, 1923, to 3/30, 1923  
 that I last saw ~~him~~ her alive on 3/30, 1923  
 and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
General Tuberculosis

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

18 Where was disease contracted \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 If not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_  
 Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_  
 (Signed) R. R. McHenry, M. D.  
 19 (Address) Shigman 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 Shigman DATE OF BURIAL 4/7 1923

20 UNDERTAKER Shigman ADDRESS Shigman  
Shigman Ford Co

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.

CONFIDENTIAL

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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, ocellulitis, 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.

11874