

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

1. PLACE OF DEATH

County Clark
 Township Vernon
 City St. Clair

Registration District No. 189
 Primary Registration District No. 5263

File No. 29583
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Andrew Jackson Deming

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) 44 years (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) Married

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 26, 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
71 1 10

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) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Perry Deming

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Almira James

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

14. INFORMANT Mrs. A. J. Deming (Address) Alexandria, Mo.

15. FILED Oct 9, 1923 F. A. S. Rebo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 6, 1923

17. I HEREBY CERTIFY, That I attended deceased from at _____, 1923 to at _____, 1923 that I last saw him alive on Oct 6, 1923, and that death occurred, on the date stated above, at _____ 11 A. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

General Peritonitis

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

18. DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

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

*State the DISEASE CAUSING DEATH, or in deaths from VOLUNTARY 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 Mound Cem. Lee Co. Iowa DATE OF BURIAL Oct. 9, '28
Jackson Twp. Outside

20. UNDERTAKER M. W. Cunningham, ADDRESS Keokuk, Iowa.

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 "Asteria," "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.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

1. PLACE OF DEATH
 County Clark Registration District No. 189 File No. 29583
 Township Vernon Primary Registration District No. 5263 Registered No. _____
 City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME Andrew Jackson Deming
 (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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>		
5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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 _____				
9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____				
PARENTS	10. NAME OF FATHER _____			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____			
	12. MAIDEN NAME OF MOTHER _____			
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____				
14. INFORMANT _____ (Address) _____				
15. FILED <u>Oct 7, 1923</u> <u>J. A. S. Rebo</u> REGISTRAR				

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>Oct 6, 1923</u>	
17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw h. _____, 19____, and that death occurred, on the date stated above, at _____.	
THE CAUSE OF DEATH* WAS AS FOLLOWS: _____ _____ _____	
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.	
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) <u>J. A. S. Rebo</u> , M. D. _____, 19____ (Address)	
*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 _____	DATE OF BURIAL 19____
20. UNDERTAKER _____	ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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