

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 Miller
 County Miller Registration District No. 561 File No. 15350
 Township Saline or _____ Primary Registration District No. 57559 Registered No. _____
 Village _____ or _____ City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Chas. Walter

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M.</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Widowed</u>
DATE OF BIRTH <u>Dec 3 1839</u> (Month) (Day) (Year)		
AGE <u>84 yrs. 5 mos. 4 ds.</u>		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work. <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Kentucky</u>		
PARENTS	NAME OF FATHER <u>Mason W. Bell</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't Know</u>	
	MAIDEN NAME OF MOTHER <u>Matilda Plummer</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't Know</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 7 1924
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1924, to May 7, 1924, that I last saw him alive on May 1, 1924, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
92A
90

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

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

(Signed) T. L. Glover M. D.
5/7 1924 (Address) Eugene

*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 Spring Garden DATE OF BURIAL May 8 1924
 UNDERTAKER W. A. Phelps ADDRESS Eldon

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs. John Bell
 (ADDRESS) Eugene
 Filed _____, 191_____
 REGISTRAR

PLACE OF DEATH

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

County _____

Township _____ File No. _____

or _____

Village _____ Primary Registration District No. _____ Registered No. _____

or _____

City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____, 191____, to _____, 191____,	(Day) _____, 191____ (Year)
AGE	_____ yrs., _____ mos., _____ 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) _____	
NAME OF FATHER	_____	
BIRTHPLACE OF FATHER	(City or town, State or foreign country) _____	
MAIDEN NAME OF MOTHER	_____	
BIRTHPLACE OF MOTHER	(City or town, State or foreign country) _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____ (Month) _____, 191____ (Day) _____, 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

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

The CAUSE OF DEATH* was as follows:

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

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

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

*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	DATE OF BURIAL
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. All causes 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**

1. PLACE OF DEATH
 County Miller Registration District No. 561 File No.
 Township Saline Primary Registration District No. 57552 Registered No.
 City (No.) St. Ward

2. FULL NAME Chas Walker
 (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 Widowed
 5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 3 1839

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>84</u>	<u>5</u>	<u>4</u>	

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1924

17. I HEREBY CERTIFY, That I attended deceased from May 6 1924, to May 7 1924 that I last saw him alive on May 1 1924, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) J. Lee Glover, M. D.
 , 19 (Address) Eugene Mo

9. BIRTHPLACE (CITY OR TOWN) Kentucky
 (STATE OR COUNTRY)

10. NAME OF FATHER Mason Walker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Abigail Plummer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY)

14. INFORMANT Mrs. John Bell
 (Address) Eugene

15. FILED Esso 19 24 Belle Hayes
Eldon, Mo REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Spring Garden DATE OF BURIAL May 8 1924

20. UNDERTAKER W. A. Phillips ADDRESS Eldon

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

CAUSE OF DEATH in plain English so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

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 neoplasm); *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.