

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

Do not use this space.

1. PLACE OF DEATH

County Scott
Township.....
City Oran (No.....) (Ward.....)

Registration District No. 820
Primary Registration District No. 4496

File No. 36842
Registered No.

2. FULL NAME

Harold Wainman
(a) Residence. No. Oran Mo St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. 24 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) at home

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/11 1924

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF at home

17. I HEREBY CERTIFY, That I attended deceased from from Dec 9, 1924, to Dec 11, 1924 that I last saw him alive on Dec 11, 1924, and that death occurred, on the date stated above, at 4:30 P. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 17 - 1922

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 9 24

Burial

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

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

9. BIRTHPLACE (CITY OR TOWN) Oran Mo (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: Place of death

10. NAME OF FATHER William P. Wainman

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF WAS THERE AN AUTOPSY? No

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

WHAT TEST CONFIRMED DIAGNOSIS: Am H. Wainman, M. D. (Signed) Am H. Wainman, M. D.

12. MAIDEN NAME OF MOTHER Wilda Wainman

2/11, 1924 (Address) Oran Mo

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Iud (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 Wm P. Wainman (Address) Oran Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Plainville Iud DATE OF BURIAL 12/13 1924

15. FILED 3/10 1925 J. J. Dickman REGISTRAR

20. UNDERTAKER T. S. Heineman & Co ADDRESS Oran 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, 8 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 child-birth 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: "Certificate 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**

1. PLACE OF DEATH

County Scott Registration District No. 820 File No. _____
 Township _____ Primary Registration District No. 4496 Registered No. _____
 City Osage (No. _____) St. _____ Ward _____

2. FULL NAME

Harold Weisman

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 17 - 1922

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 9 24

8. OCCUPATION OF DECEASED

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

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) Iud

14. INFORMANT _____
 (Address) _____

15. FILED 1-10-25 J. J. Weisman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 - 1924

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Grand - Fell in Kettle boiling hot water
 (duration) yrs. 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) _____, M. D.
 , 19____ (Address) _____

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

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.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

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