

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

Do not use this space

18419

1. PLACE OF DEATH

County Lancaster
Township Cannon
City Cannon

Registration District No. 467
Primary Registration District No. 4280
(No. 502 W. Nat. Ozark Hosp. St. 31 Ward)

File No. _____
Registered No. 97

2: FULL NAME William Coalhoun

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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 Mary Coalhoun (or) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 27 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 2 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer and Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): _____
(c) Name of employer: _____

9. BIRTHPLACE (CITY OR TOWN): Idaho
(STATE OR COUNTRY)

10. NAME OF FATHER: August Coalhoun

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

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): " "
(STATE OR COUNTRY)

14. INFORMANT: A. O. Coalhoun
(Address) Aurora Mo

15. June 13 1925 Mary D. Melton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13th 1925

17. I HEREBY CERTIFY that I attended deceased from: June 1, 1925 to: June 12, 1925 that I last saw him alive on: June 12, 1925 and that death occurred, on the date stated above, at: 11202

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General debility
CONTRIBUTORY (SECONDARY): prostate abscess
(duration) yrs. mos. da. 30

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: yes DATE OF: June 6-25

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. W. Knudsen M. D.

6/13, 1925 (Address): Aurora Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) - NATURE AND NATURE OF INJURY, and: (2) - whether ACCIDENTAL, SUICIDAL, or HOMICIDAL (See reverse side for additional space).

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St. Paul Central Cemetery DATE OF BURIAL: June 13 1925

20. UNDERTAKER: 176-2020 Mauls King ADDRESS: Aurora Mo

J. E. Melton

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 septi emia," "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**

1. PLACE OF DEATH.

County Lawrence Registration District No. 467 File No. _____
 Township _____ Primary Registration District No. 4280 Registered No. 37
 City Anna (No. _____) St. _____ Ward _____

2. FULL NAME William Calhoun

(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) m

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) _____

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. 8-21-25 Mary D. Melton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 12 1925

17. I HEREBY CERTIFY That I attended deceased from _____ 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:

*General peritonitis
product of femoral abscess
was of traumatic origin by patient*
 CONTRIBUTORY (SECONDARY) prostate abscess
 (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? _____

H (Signed) P. D. Stewart, M. D.
8-21-25 (Address) Anna 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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

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

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