

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

Do not use this space.

20525

1. PLACE OF DEATH

County Waseonade
Towship Clay
City (No. _____) _____

Registration District No. 302
Primary Registration District No. 6231

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

2. FULL NAME

William Lockhart

(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) August 4th 1879

7. AGE YEARS MONTHS DAY If LESS than 1 day, _____ hrs. or _____ min.
47 11 8

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

9. BIRTHPLACE (CITY OR TOWN) Oak Hill, Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER John Lockhart

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

12. MAIDEN NAME OF MOTHER Katherine Kosark

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

14. INFORMANT Mrs. William Lockhart
(Address) Owensville Mo

15. FILED _____ 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____
_____ 1923 to _____ July 12 1925
that I last saw him alive on _____ 22nd July 1925, and that death occurred, on the date stated above, at _____
_____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus paralysis

(duration) 3 yrs. _____ mos. _____ ds.

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? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Chas. B. Stone M. D.
, 19 _____ (Address) Owensville 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 Bear Cr. Cemetery DATE OF BURIAL July 14 1925

20. UNDERTAKER W. F. Gettenstroeter ADDRESS Owensville 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, 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, 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.

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

1. PLACE OF DEATH.

County..... Dossade Registration District No. 302 File No.
 Township..... Clay Primary Registration District No. 6231 Registered No.
 City..... (No.) St. Ward)

2. FULL NAME..... William Lockhart

(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 (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4th 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
47 11 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Farming
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... Oak Hill Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER..... John Lockhart

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

12. MAIDEN NAME OF MOTHER..... Katherine Kosach

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

14. INFORMANT..... Mrs William Lockhart
 (Address)..... Ormsville Mo.

15. FILED..... W. F. Gottenbrot
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from Oct to July 12, 1925 that I last saw h. in alive on July 7, 1925, and that death occurred, on the date stated above, at 7 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus Paralytic

CONTRIBUTORY (SECONDARY) 57 3 yrs. + mos. + ds.
 (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)..... Chas A. Wood M. D.
 , 19 (Address) Ormsville Mo.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL..... Ben Dr - Cemetery DATE OF BURIAL..... July 14 1925

20. UNDERTAKER..... W. F. Gottenbrot ADDRESS..... Ormsville Mo.

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 57

Revised United States Standard Certificate of Death

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

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