

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

Do not use this space.

26341

1. PLACE OF DEATH Caldwell
 County Caldwell Registration District No. 94
 Township Brekenridge Primary Registration District No. 14656
 City Brekenridge (No.) (Ward)

2. FULL NAME Dr Joseph Singer Halstead
 (a) Residence No. St. Ward
 (Usual place of abode)
 Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No.
 Registered No. 16

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 4 1818
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 107 6 9
 8. OCCUPATION OF DECEASED Retired Physician
 (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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-13 1926
 17. I HEREBY CERTIFY, That I attended deceased from 9-8, 1926, to 9-13, 1926, that I last saw alive on 9-11, 1926, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia (Hypostatic)
following Hay Fever
 (duration) 5 yrs. mos. da.
 CONTRIBUTORY (SECONDARY) Periodical Hay Fever
 (duration) 25 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) J. F. Thompson, M. D.
9-16, 1926 (Address) Brekenridge, 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.)

9. BIRTHPLACE (CITY OR TOWN) Louisville (STATE OR COUNTRY)
 10. NAME OF FATHER Alexander Halstead (STATE OR COUNTRY) Ky.
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER M. Singer (STATE OR COUNTRY)
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address) R. E. Chaffin Breckenridge, Mo.
 15. FILED 9-13 1926 E. W. Thompson REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Rose Hill Cemetery DATE OF BURIAL Sept 16 1926
 20. UNDERTAKER J. F. McKee ADDRESS Brekenridge 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, 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.

Dr. Joseph Singer Halstead insist there was no symptom of pneumonia. For fifty years he has been subject to chronic Bronchitis and Hay Fever beginning the third week in August, lasting until frost.

Owing to his advanced age it might be of interest to tell you he has taken a laxative every second day for the past seventy-five years.

He walked about his room attending to natures calls etc the day of his death.

He quietly fell asleep and not awaken.

Sincerely yours,

Dr. E. A. Thompson

26341

1925

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

1. PLACE OF DEATH.

County Caldwell Registration District No. 94 File No. _____
 Township _____ Primary Registration District No. 4056 Registered No. _____
 City Breckinridge (No. _____) St. _____ Ward _____

2. FULL NAME

Joseph Singer Halstead
 (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

Dr. O'Bryant is dead and the family

SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) w

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR)

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

Trade, profession, or particular kind of work _____
 General nature of industry, business, or establishment in which employed (or employer) _____
 Name of employer _____

BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

INFORMANT _____
 (Address) _____

FILED _____ 19 _____

REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 13 19 20
 17. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____, and 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:

Pneumonia (Hypostatic) following Hay fever

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) _____, 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 _____

SUPPLEMENTARY

103

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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