

N. B.—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 1855**

PLACE OF DEATH
 County Montgomery Co.
 Township Barren Registration District No. 938 File No. _____
 or _____
 Village Barren Primary Registration District No. 5782 Registered No. _____
 or _____
 City Barren (NO. _____) St.; _____ Ward _____

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

FULL NAME Joe W. McCormack

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Boy</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED <u>married</u> WIDOWED OR DIVORCED <i>(Write the word)</i>	DATE OF DEATH <u>Jan</u> (Month) <u>8</u> (Day) <u>1916</u> (Year)	
DATE OF BIRTH <u>December 23rd</u> <u>23rd</u> <u>1926</u> <u>12</u> (Month) <u>23</u> (Day) <u>1926</u> (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Dec 25</u> , 19 <u>25</u> , to <u>January 8</u> , 19 <u>26</u> , that I last saw him alive on <u>January 6th</u> , 19 <u>26</u> , and that death occurred, on the date stated above, at <u>11 A.M.</u>	
AGE _____ yrs. _____ mos. <u>6</u> ds.			The CAUSE OF DEATH* was as follows: <u>A Cold followed by</u> <u>Pneumonia</u> <u>10 AM</u>	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory <u>to Cold</u> (SECONDARY) (Duration) _____ yrs. _____ mos. <u>None</u> ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Montgomery</u>			(Signed) <u>W W Daniels</u> M. D. <u>Jan 9</u> , 19 <u>26</u> (Address) <u>New Florence Mo</u>	
PARENTS	NAME OF FATHER <u>William McCormack</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER <u>Anna Mabel McCormack</u>		Where was disease contracted if not at place of death? _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Monroe Co Mo</u>		Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W J McCormack</u> (ADDRESS) <u>New Florence Mo</u>			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 19 <u>16</u>	
Filed <u>2/8</u> 19 <u>26</u> <u>E Gilboe</u> REGISTRAR			UNDERTAKER <u>W W Daniels</u> ADDRESS _____	

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ 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
(#/ wife the word)

DATE OF BIRTH _____ (Month) _____, 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) _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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 _____ m. The CAUSE OF DEATH* was as follows:

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) _____

Contributory
(SECONDARY)

(Signed) _____ 191____ (Address) _____ M. D. _____

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

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

*State the Disease Causing Death, or, in deaths from Violent Cause, 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. State _____ yrs. _____ mos. _____ ds. In the _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

_____ DATE OF BURIAL _____ 191____

UNDERTAKER

_____ ADDRESS _____

Filled _____ 191____

REGISTRAR

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Montgomery Registration District No. 938 File No.
 Township Wasselle Primary Registration District No. 5780 Registered No.
 City (No.) St. Ward (No.)

2. FULL NAME Joe Mc Cormack
 (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) SM

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 23-26

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin. 16

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) New Florence Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER W J Mc Cormack

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

12. MAIDEN NAME OF MOTHER Elizabeth Kuntz

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

14. INFORMANT (Address) W J Mc Cormack
1111 New Florence Mo

15. FILED Jan 9 1926
E. Gibson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1926

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Caused followed by
Pneumonia of
labor
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1010
 (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) W. W. Daniels M. D.
 , 19 1926 New Florence 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
Pratt cemetery Jan 9 1926

20. UNDERTAKER ADDRESS
W. T. Redman

N. B.—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.

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

MISSOURI STATE BOARD OF HEALTH

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; Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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.

5-1851-S