

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.

FEB 25 1926

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

Do not use this space.
 37961a

1. PLACE OF DEATH
 County Iron Registration District No. 1159 File No. _____
 Township Iron Primary Registration District No. 5549 Registered No. 2
 City Bellemeade (No. _____) St. _____ Ward _____

2. FULL NAME James Mulford Russell
 (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 male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 2
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/24 1926
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
1 10 2
 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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1926
 17. I HEREBY CERTIFY, That I attended deceased from 12/24/26, 1926, to 12/26, 1926, that I last saw him alive on 12/25, 1926, and that death occurred, on the date stated above, at 9 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic meningitis

CONTRIBUTOR (SECONDARY) [Signature] (duration) yrs. mos. da. _____
 (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? no
 WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) W. P. [Signature], M. D.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL California DATE OF BURIAL 12/27 1926
 20. UNDERTAKER Norman R. White ADDRESS Bellemeade

9. BIRTHPLACE (CITY OR TOWN) Bellemeade (STATE OR COUNTRY) Mo
 10. NAME OF FATHER Hubert Russell
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bellemeade (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Sarah Keesling 12/26, 1926 (Address) California Mo
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bellemeade (STATE OR COUNTRY) Mo
 14. INFORMANT Hubert Russell (Address) Bellemeade
 15. FILED 12/26 1926 [Signature] REGISTRAR

*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.)

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.

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

ALL INFORMATION REQUESTED
HEREIN SHOULD BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 1159 File No. _____
 Township Greene Primary Registration District No. 5549 Registered No. 2
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

James Mulford Russell
 (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) S
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 24, 1923
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 | 10 | 2 | _____

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) _____

PARENTS
 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. FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 19 26
 17. I HEREBY CERTIFY That I attended deceased from _____ to _____, 19____, and that I last saw him/her alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

 _____ (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)

*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 _____

Every item of information should be fully supplied. AGE should be stated IN FULL. PHYSICIANS should state the cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE FEES FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

OF DISTRICT

SECTION DIVISION OF DEATH

(1) Name of Deceased (Last, First, Middle Initial)

IN (1966-7)

(2) Date of Death (Month, Day, Year)

(3) Age at Death (Years, Months, Days)

(4) Sex (Male/Female)

(5) Race (White/Black/Other)

(6) Marital Status (Single/Married/Widowed/Divorced)

(7) Occupation (at time of death)

CO-CERTIFICATION

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

Signature of Informant

Date

THE CAUSE OF DEATH AND EXTENT OF INJURY

1. Cause of Death (Immediate Cause)

IMMEDIATE CAUSE OF DEATH

2. Date of Death (Month, Day, Year)

MEDICAL CERTIFICATION OF DEATH

3. Signature of Physician

Date

PERSONAL AND STATISTICAL PARTICULARS

4. Name of Deceased (Last, First, Middle Initial)

5. Date of Birth (Month, Day, Year)

6. Sex (Male/Female)

7. Race (White/Black/Other)

8. Marital Status (Single/Married/Widowed/Divorced)

9. Occupation (at time of death)

1966-5-5

COMMISSIONER OF DEATH
BUREAU OF VITAL STATISTICS
MISSOURI STATE BOARD OF HEALTH