

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

Do not use this space

137

**1. PLACE OF DEATH**

County Bollinger

Registration District No. 69

Township Waynes

Primary Registration District No. 4708

City (No. ....)

File No. ....

Registered No. ....

St. .... Ward)

**2. FULL NAME**

William Perry Blouin

(a) Residence. No. .... St. .... Yrd. ....  
(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED W  
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 19 27

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

I HEREBY CERTIFY That I attended deceased from Jan 1 19 27 to Jan 5 19 27 and that I last saw him alive on Jan 2 19 27 and that death occurred, on the date stated above, at 2 P. M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 19 22

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>4</u>	<u>4</u>	<u>22</u>	

Branch Pneumonia

**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 ✓

CONTRIBUTORY (SECONDARY) 10/11 (duration) yrs. mos. da.

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Mo

18. WHERE WAS DISEASE CONTRACTED at home

IF NOT AT PLACE OF DEATH, .....

10. NAME OF FATHER Joe Blouin

DID AN OPERATION PRECEDE DEATH. no DATE OF ✓

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

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Mary Alice Hask

WHAT TEST CONFIRMED DIAGNOSIS none

(Signed) A. T. Kirkpatrick, M. D.

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

, 19 (Address)

14. INFORMANT (Address) A. T. Blouin  
Brookline Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 1-7-27 A. T. Kirkpatrick REGISTRAR

20. UNDERTAKER ADDRESS

Butte County 1-7 19 27  
Ralph Blouin

E.—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.

1927

# 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**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**  
 County Rollinger Registration District No. 69 File No. \_\_\_\_\_  
 Township Waynes Primary Registration District No. 15108 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME** William Perry Chouinger  
 (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) Single

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF** \_\_\_\_\_

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** \_\_\_\_\_

<b>7. AGE</b>	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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**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)** \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan 5, 19 27

**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 \_\_\_\_\_.**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Pneumonia  
Chouinger  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**CONTRIBUTORY (SECONDARY)** 1000  
 (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.)

<b>19. PLACE OF BURIAL, CREMATION, OR REMOVAL</b>	<b>DATE OF BURIAL</b>
_____	_____ 19____
<b>20. UNDERTAKER</b>	<b>ADDRESS</b>
_____	_____

**SUPPLEMENTARY**

**14. INFORMANT (Address)** \_\_\_\_\_

**15. FILED** 1-11-27 W. K. Kierpatrick  
 REGISTRAR

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

N. every item of information OF DEATH in plain text do carefully supplied. AGE should be stated EXACTLY. PHYSICIANS who at it may be properly classified. Exact statement of OCCUPATION if any im

