

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

1. PLACE OF DEATH *Exp. St. Lawrence*  
County *Walden* Registration District No. *722*  
Township *Walden* Primary Registration District No. *730*  
City (No. *5285*) *5175* St. \_\_\_\_\_ Ward \_\_\_\_\_  
Registered No. \_\_\_\_\_  
2. FULL NAME *James Lloyd Eskine*  
(a) Residence No. *Walden Mo. 64604* 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) *Single*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 11 1926*  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*7 20*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

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

10. NAME OF FATHER *George Lee Eskine*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Exp. St. Lawrence*  
(STATE OR COUNTRY) *Mo.*  
12. MAIDEN NAME OF MOTHER *Beth May Miller*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Exp. St. Lawrence*  
(STATE OR COUNTRY) *Mo.*

14. INFORMANT *George Lee Eskine*  
(Address) *Walden Mo. 64604*  
15. FILED *1/14 27* 19 *27* *J. M. Hagle* REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 1 1927*  
17. I HEREBY CERTIFY That I attended deceased from *Dec 10 1926* to *Dec 30 1926*  
that I last saw him alive on *11/11* 19 *26* and that death occurred, on the date stated above, at \_\_\_\_\_ m.

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cerebral meningitis*  
*from acute mastoiditis*  
*8/13* (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) *8/13* (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) *Paul K. Williams* M. D.  
(Address) *Cape Girardeau Mo.*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state 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 *Trinidad Cemetery* DATE OF BURIAL *Jan 2 1927*

20. UNDERTAKER *Trinidad Mo.* ADDRESS *Trinidad 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 neoplasma); *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: "Certificate 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  
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CERTIFICATE OF DEATH

ALL INFORMATION REQUESTED  
HEREIN MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
County Cape Girardeau Registration District No. 122 File No. \_\_\_\_\_  
Township Welsh Primary Registration District No. 5175 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME James Lloyd Eakins  
(a) Residence, No. Advance Mo. St. R.F.D. 3 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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 1927  
17. \_\_\_\_\_

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

HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
Dec 11 1926 to Dec 30 1926  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date signed above at \_\_\_\_\_, Mo.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 11, 1926

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cerebral meningitis  
prod acute meningitis

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
3 20

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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 \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Advance Mo. R.F.D. 3  
(STATE OR COUNTRY)

10. NAME OF FATHER George Lee Eakins

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

12. MAIDEN NAME OF MOTHER Betha May Miller

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

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Paul R. Williams, M.D.  
Dec 7 1926 (Address) Cape Girardeau, 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.)

14. INFORMANT George Lee Eakins  
(Address) Advance Mo. R.F.D. 3

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairview Cemetery DATE OF BURIAL Jan 2 1927

15. FILED 1-10 1927 M.E. Morrison REGISTRAR  
Delta Mo

20. UNDERTAKER Lorberg F.W. Co. ADDRESS Cape Girardeau Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact status of OCCASION is very important. REGISTERARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY COMPLETE

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