

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

1957

1. PLACE OF DEATH

County Newton
Township Dayton
City Rainie

Registration District No. 611
Primary Registration District No. 5015

File No. ✓
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Wm. Adams Warren

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? _____ yrs. mos. ds. (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 Single
(Write the word)

DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 - 1927

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

17. I HEREBY CERTIFY That I attended deceased from Jan 1, 1927, to Jan 27, 1927 that I last saw him alive on Jan 27, 1927, and that death occurred, on the date stated above, at 9:30 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29 1853

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Flu

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 4 29

CONTRIBUTORY (SECONDARY) 11B
(duration) _____ yrs. mos. ds.

8. OCCUPATION OF DECEASED

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

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kentucky

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

10. NAME OF FATHER Thos. A. Warren

19. WAS THERE AN AUTOPSY? _____

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

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. P. Hendley, M. D.

12. MAIDEN NAME OF MOTHER Paula Campbell

(Address) Seneca Mo.

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

*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 Walter Warren
(Address) Rainie Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Galena - Kan DATE OF BURIAL _____

15. FILED _____ 19 _____ REGISTRAR

20. UNDERTAKER Bowen & Son ADDRESS Galena K.

N. B.—By _____ PHYSICIANS should state EXACTLY _____ OCCUPATION is very important that it may be properly classified.

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"); *Broncho-pneumonia* ("Pneumonia," *lunga di d. gittafinito*); *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 CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Newton Registration District No. 611 File No.
 Township Dayton Primary Registration District No. 5815 Registered No.
 City St. Ward)

2. FULL NAME Wm Adam Warren
 (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

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.

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)

MAIDEN NAME OF MOTHER

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

FORMANT (Address)

15. FILED 1/24 1927 E. G. Morris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 27, 1927

17. I HEREBY CERTIFY That I attended deceased from 19... to 19... (duration) yrs. mos. ds.

that I last saw h. alive on 19... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

20. UNDERTAKER ADDRESS

Galena Hall 1/29 1927
Boice Son Galena, Mo.

N. B. Every item of information should be carefully supplied. Exact statement of cause of death should be stated. Physicians should state cause of death in plain terms, so that it may be understood. REGISTRATION is very important. AS PRESCRIBED BY LAW.

SUPPLEMENTARY

