

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 26 1927

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

Do not use this space

11265

1. PLACE OF DEATH

County Callaway  
Township Englewood  
City Englewood

Registration District No. 212  
Primary Registration District No. 5292

File No. ....  
Registered No. 4  
St. .... Ward)

2. FULL NAME

Infant Golden

(a) Residence No. .... St. .... Ward. ....  
(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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

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

S

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1927

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1927, to April 8, 1927 that I last saw him alive on April 8, 1927, and that death occurred, on the date stated above, at 7 a. m.

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Erysipelas

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

Mar 26-27

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

13

(duration) yrs. mos. da. 3

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

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

Englewood Mo  
Call Co

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) D. Lee Gibson, M. D.  
, 19 (Address) Englewood

\*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.)

PARENTS

10. NAME OF FATHER

Ranier R Golden

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

Miller Co

12. MAIDEN NAME OF MOTHER

Mabel Haffelt

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

Miller Co. Mo

14. INFORMANT

Ranier Golden

(Address) Englewood

15. DATE

May 19 1927

D. Lee Gibson  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Spring Garden Cem

Apr. 9 1927

20. UNDERTAKER

ADDRESS

Shell Merc. Co

Englewood

# 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 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 "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "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 Cole Registration District No. 212 File No. ....  
 Township Clark Primary Registration District No. 5292 Registered No. 4  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

Infant Golden  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 8 1927

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

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

Cerebral malaria  
affected brain first; extending  
over entire body, as cause of  
stupor from extension of disease

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)

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

18. WHERE WAS DISEASE CONTRACTED 21 B

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

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

WAS THERE AN AUTOPSY?.....

12. MAIDEN NAME OF MOTHER

WHAT TEST CONFIRMED DIAGNOSIS.....

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

(Signed)....., M. D.  
 , 19 (Address)

14. INFORMANT (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.

15. May 10 27 J. L. Glover REGISTRAR

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

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

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