

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

25156 a

1. PLACE OF DEATH

County Platte Registration District No. 696 File No. _____
 Township Pratt Primary Registration District No. 4419 Registered No. 21
 City Pratt (No. _____) St. _____ Ward _____

2. FULL NAME

G. A. Clements
 (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 <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Don't know month or day</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>7 1850</u>		
7. AGE	YEARS <u>77</u>	MONTHS _____
	DAYS _____	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>at home</u> (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) <u>Mo</u>		
PARENTS	10. NAME OF FATHER <u>Johnathan Clements</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo</u>	
	12. MAIDEN NAME OF MOTHER <u>Williams</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo</u>	

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-12-1927
 17. I HEREBY CERTIFY, That I attended deceased from July 24-27 19____, to Aug 13 1927, and that I last saw h. m. alive on Aug 13 1927, and that death occurred, on the date stated above, at _____ a _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
228
137
135 B- (duration) _____ yrs. _____ mos. 7 da.
 CONTRIBUTORY (SECONDARY) Influenza (duration) _____ yrs. 2 mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED Don't know
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? no. DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Bubkitt diagnosis
 (Signed) Henry M. O'Neil, M. D.
Aug-14, 1927 (Address) 1940 Broadway 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 Andrew Clements
 (Address) Swickville Mo
 15. FILED Nov-3-27 May 73 Knight
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Second Creek Cem DATE OF BURIAL 7-14 1927
 20. UNDERTAKER L. H. Rollins ADDRESS Platte City Mo

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.

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 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: "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
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CERTIFICATE OF DEATH**

FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Platte Registration District No. 696 File No. 25156
 Township Tracy Primary Registration District No. 4419 Registered No. 21
 City St. Joseph (No. _____) St. _____ Ward _____

2. FULL NAME G. A. Clements
 (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
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (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) _____
 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) Aug 13 1927
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw him _____ give on _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicall Hemorrhag
 CONTRIBUTORY (SECONDARY) Inflammation of bladder retention of
urine (duration) _____ yrs. _____ mos. _____ ds.
 18. WHERE WAS DISEASE CONTRACTED _____ (duration) _____ yrs. _____ mos. _____ ds.
 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.

14. INFORMANT _____ (Address) _____
 15. FILED _____, 19____ REGISTRAR _____
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____
 20. UNDERTAKER _____ ADDRESS _____

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

SUPPLEMENTARY

S-2515 6-42