

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH **87278**

1 PLACE OF DEATH

County *St. Louis*
Township *Central*
Village
City (NO. St. Ward)

Registration District No. *412* File No.
Primary Registration District No. *5570* Registered No. *845*

If death occurred in a hospital or institution, give its NAME instead of street and number.

2 FULL NAME *William H. Caff*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *W* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *Oct 3 1883*
(Month) (Day) (Year)

7 AGE *44* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) *Benton Co Mo*

PARENTS
10 NAME OF FATHER *Jesse H Caff*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Benton Co Mo*
12 MAIDEN NAME OF MOTHER *Walter H. Sunders*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Ill*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15 Filed *12/27 1927* *W. H. Schaefer* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec 24 1927*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *June 1923* 191 to *Dec 24* 1927
that I last saw him alive on *Dec 24* 1927
and that death occurred, on the date stated above, at *2* m.

The CAUSE OF DEATH* was as follows:
Enlargement of heart
interd. Regurgitation
92A
45B (Duration) *4* yrs. mos. ds.
11B

CONTRIBUTORY (Secondary) *Influenza*
(Signed) *W. H. Schaefer* M. D.
(Address)

*State of Disease Causing Death, or, in deaths from Violent Causes, state (1) Manner of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Waverly Cem* DATE OF BURIAL *Dec 27 1927*

20 UNDERTAKER *W. H. Schaefer* ADDRESS *W. H. Schaefer*

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, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

PLACE OF DEATH.

County Jasper
Township Duval
City..... (No. St. Ward)

Registration District No. 412
Primary Registration District No. 3-3-20

File No.
Registered No. 8

2. FULL NAME William H. Capp

(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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3 - 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 2 23

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)

14. INFORMANT Hattie M Burden (Address)

15. FILED 12/27 1927 Charles E Scape REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1927

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, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY) (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.

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

20. UNDERTAKER ADDRESS

IF THIS FORM IS NOT RECEIVED A FEE WILL BE CHARGED

S-37278