

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

1. PLACE OF DEATH

County Iron Registration District No. 390
Township Union Primary Registration District No. 5545
City Sabula (No. _____) St. _____ Ward _____

File No. 27146
Registered No. 2710

2. FULL NAME

Walter Lee Fahlend
(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 (write the word) Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 9, 1927
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 1 — 21

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) Sabula
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Wm A. Fahlend

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

12. MAIDEN NAME OF MOTHER Della E. Miller

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

14. INFORMANT W. G. Fahlend
(Address) Sabula

15. FILED 10 28 B.C. Gunter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 30, 1928
17. I HEREBY CERTIFY That I attended deceased from Aug 27, 1928 to Aug 30, 1928
that I had saw h.s.m. alive on Aug 30, 1928, and that death occurred, on the date stated above, at 5 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial pneumonia
(duration) — yrs. — mos. 7 ds.

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

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) R.C. Figgell, M.D.

Aug 30, 1928 (Address) Annapolis 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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Des Arc DATE OF BURIAL Aug 31 1928

20. UNDERTAKER Ed Huggins ADDRESS Sabula Mo.

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

PERMANENT

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.

Examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Sales-*
(b) *Grocery*; (a) *Foreman*, (b) *Automobile fac-*

The material worked on may form part of the statement. Never return "Laborer," "Fore-
"Manager," "Dealer," etc., without more
e specification, as *Day laborer, Farm laborer,*
er—Coal mine, etc. Women at home, who are
—ed 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 occupa-
tion at beginning of illness. If retired from busi-
ness, that fact may be indicated thus: *Farmer (re-*
tired, 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; Broncho-*
pneumonia ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name ori-
gin; "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 in-
tercurrent) affection need not be stated unless im-
portant. Example: *Measles* (disease causing death),
29 ds.; *Bronchopneumonia* (secondary), 10 ds.
Never report mere symptoms or terminal conditions,
such as "Asthenia," "Anemia," (merely symptom-
atic), "Atrophy," "Collapse," "Coma," "Convul-
sions," "Debility" ("Congenital," "Senile," etc.),
"Dropsy," "Exhaustion," "Heart failure," "Hem-
orrhage," "Inanition," "Marasmus," "Old age,"
"Shock," "Uremia," "Weakness," etc., when a
definite disease can be ascertained as the cause.
Always qualify all diseases resulting from child-
birth 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 rail-*
way 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 Iron Registration District No. 390 File No. _____
 Township Union Primary Registration District No. 5-3-45- Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Homer Lee Fahlend
 (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 S
(write the word)

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)

14.

INFORMANT _____
 (Address)

15. FILED 12/31 1928 B.C. Gunter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20, 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Brucella pneumoniae Primary

CONTRIBUTORY (SECONDARY) nothing
 (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 _____

WRITE PLAINLY WITH UNFADING INK... THIS IS NOT A RECEIPT... PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. N. B.—Every death is in plain terms, so that it is fully and properly classified. REGISTARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-27146