



# United States Standard Certificate of Death

by U. S. Census and American Public Health  
Association.)

**Occupation.**—Precise statement of  
is very important, so that the relative  
of various pursuits can be known. The  
lies to each and every person, irrespec-  
For many occupations a single word or  
rst line will be sufficient, e. g., *Farmer or*  
*ician, Composer, Architect, Locomo-*  
*Civil Engineer, Stationary Fireman, etc.*  
cases, especially in industrial employ-  
m, 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) Sales-*  
*man, (b) Grocery, (a) Foreman, (b) Automobile facto-*  
*tory.* The material worked on may form part of the  
second statement. Never return "Laborer," "Fore-  
man," "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 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, peritoneum, 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 undesir-  
able terms and refuse to accept certificates containing them.  
Thus the form in use in New York City states: "Certificate,  
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, hemor-*  
*rhage, 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 Linn  
Township Madawley  
City Madawley (No. ....) St. .... Ward)

Registration District No. 503  
Primary Registration District No. 4306

File No. ....  
Registered No. 3

**2. FULL NAME**

Aliey Pearman  
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M. (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 30 - 1862

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 ..... (duration) yrs. mos. ds.  
(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 Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Laura Chittok  
(Address) Cherestee Mo

15. FILED 3-20-29 E. J. Weir REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 31 1929 19

17. I HEREBY CERTIFY That I attended deceased from ..... 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:

CONTRIBUTORY (duration) yrs. mos. ds.  
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.

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

20. UNDERTAKER ADDRESS

AGE should be stated EXACTLY. PHYSICIANS should state classified. Exact statement of OCCUPATION is very important. CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. REC 3 S.

SUPPLEMENTARY

S-2350