

10391

ORIGINAL

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF VITAL STATISTICS  
STATE OF IOWA

Reg Len 346  
Prunij 5484

PLACE OF DEATH Harrison  
County 346  
Township 346  
City No. 346  
No. 346  
St. mo.  
Registered No. 7  
or Village 346

2 FULL NAME Sam Swank  
(If death occurred in a hospital or institution, give its name instead of street and number)  
(a) Residence No. St. Ward  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male  
4 COLOR OR RACE white  
5 Single, Married, Widowed, or Divorced (write the word) Married  
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Swank  
6 DATE OF BIRTH (month, day, and year) Nov 10 1855  
7 AGE Years 75 Months 13 Days 10 If less than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Contractor  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9 BIRTHPLACE (city or town) Wells Co - Iowa  
(State or country)

10 NAME OF FATHER Jacob Swank

11 BIRTHPLACE OF FATHER (city or town) Ohio  
(State or country)

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) Do not know  
(State or Country)

14 Informant Earl Coulson  
(Address) 707 1/2 mo

15 Filed 3-16, 1929 Chas Adair  
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 20, 1928, to March 7, 1929, that I last saw him alive on March 1, 1929, and that death occurred, on the date stated above, at 11:09 a.m. THE CAUSE OF DEATH\* was as follows:

Valvular Insufficiency of Aorta with Bright's Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death Colorado

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Percussion  
(Signed) W. B. ... M. D.

415, 1929 (Address) 707 1/2 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 DATE OF BURIAL  
Prysgold cemetery Ia 3/10 1929

20 UNDERTAKER ADDRESS  
A. S. ...

THIS IS A FEDERAL RECORD. Every item of information 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. See instructions on back of certificate.

PARENTS

ates Stan  
care 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 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," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaus-

tion," "Marasmus," "Shock," "Uremia," "Hemorrhage," "In-ness," etc. 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.)

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 Wayson  
Township Lincoln  
City Lincoln (No. \_\_\_\_\_) (St. \_\_\_\_\_ Ward)

Registration District No. 346  
Primary Registration District No. 5485-

File No. 10391  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Sam Swanek  
(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 m  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 10 - 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
75 3 27

**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 \_\_\_\_\_, 19 \_\_\_\_\_ Chas Adair REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1929

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

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (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 \_\_\_\_\_ 19 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Every item of information should be properly classified. AGE should be properly classified. OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, and NATURE OF INJURY, if any, should be properly classified. ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY. REGISTARS SHALL NOT RECEIVE TO BE HOLDS CERTIFICATES UNTIL Y

SUPPLEMENTARY

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