

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

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

9946

9946

1. PLACE OF DEATH

County St. Charles
Township Portage
City (Name) St. Charles

Registration District No. 756
Primary Registration District No. 5997

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Frank A. Crawford

(a) Residence, No. _____ S. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

3/12 1930

17.

I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to March 12, 1930
that I last saw him alive on March 12, 1930, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis

(duration) 2 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? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Tubercular

(Signed) C. A. Barnard, M. D.

Nov 13, 1930 (Address) Portage (St. Louis) 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.)

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

Labour

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Hest Altin
Ill.

10. NAME OF FATHER

Wm Crawford

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

Urbansaw

12. MAIDEN NAME OF MOTHER

Heller Meyer

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

Ill.

14. INFORMANT (Address)

FILED 3/14 1930 C. A. Barnard REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Cheverre Hest. Altin

DATE OF BURIAL

3/14 1930

20. UNDERTAKER

H. P. Bauer

ADDRESS

Altin

Revised United States Standard Certificate of Death

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

Occupation.—Precise statement of very important, so that the relative various pursuits can be known. The one to each and every person, irrespectively of many occupations a single word or line will be sufficient, e. g., *Farmer or an, Compositor, Architect, Locomotive Engineer, Stationary Fireman*, in any cases, especially in industrial employment, necessary to know (a) the kind of (b) the nature of the business or industry; therefore an additional line is provided for statement; it should be used only when examples: (a) *Spinner*, (b) *Cotton mill*, (c) *Grocery*, (d) *Foreman*; (e) *Auto*. The material worked on may form a second statement. Never return *reman*, "Manager," "Dealer," etc., unless precise specification, as *Day laborer, laborer—Coal mine*, etc. Women at home engaged in the duties of the household, *paid Housekeepers* who receive a salary, may be entered as *Housewife, At home*, and children, not gainfully employed, *At school* or *At home*. Care should be reported specifically the occupations of persons in domestic service for wages, as *Housemaid*, etc. If the occupation is changed or given up on account of the illness, state occupation at beginning of death. If retired from business, that should be indicated thus: *Farmer (retired)*, 6 persons who have no occupation whatsoever.

Cause of Death.—Name, first, the primary affection with which the death (the primary affection with which the death is caused), using always the same term for the same disease. Examples: *Fever* (the only definite synonym is *meningitis*); *Diphtheria* (never report *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 neoplasm); *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. This 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.

CERTIFICATE OF DEATH

THIS SUPPLEMENTARY.

9946

1. PLACE OF DEATH
 County St. Charles Registration District No. 756 File No. _____
 Township Portage Primary Registration District No. 5-997 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Frank A. Crawford
 (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 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 4 - 1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>30</u>	<u>8</u>	<u>8</u>	

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 George Crawford
 (Address) West altar st.

15. FILED 3/14 1930 ca Barnard
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/12 1930

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) _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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** _____

SUPPLEMENTARY

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

9766-5