

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

6501

1. PLACE OF DEATH

County Oregon Registration District No. 636 File No. 3
 Township Goble Primary Registration District No. 5841 Registered No. 3
 City (No.) St. Ward

2. FULL NAME

Johnson Beane Sprague
 (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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 7 1856

7. AGE
 YEARS 74 MONTHS 11 DAYS 27
 IF LESS than 1 day, hrs. or min.

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

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

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Johnson Sprague
 (Address)

15. FILED 3/16 1931 Enoch Bailey
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1931

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on..... 18..... and that death occurred, on the date stated above, at..... 3..... p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Valvular Disease
Hurt Disease

CONTRIBUTORY (SECONDARY) Rheumatism
 (duration) 2 yrs mos. da.

18. WHERE WAS DISEASE CONTRACTED no
 IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Martha Sprague Whitson, M.D.
 , 19 (Address) altor MO R 2

*State the DISEASE CAUSING DEATH, or in death 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 Cave Spring **DATE OF BURIAL** 2/5 1931

20. UNDERTAKER M.P. Hines acaty **ADDRESS** altor MO R 2

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 the same accepted term for the same disease. *Cerebrospinal fever* (the only definite sy "Epidemic cerebrospinal meningitis"); (avoid use of "Croup"); *Typhoid fever* (ne

"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," "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*; ~~stroke~~ *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. 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 to 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.

6501

1. PLACE OF DEATH
 County Oregon Registration District No. 636 File No. _____
 Township Gable Primary Registration District No. 5841 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Johnson Sprague
 (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) M

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 2/16/31 Enoch Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1931

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:

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) A. B. Jones, M. D.
Alton Mo., 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 _____ |

SUPPLEMENTARY

MARGIN: Every item of information shown, WITH UNFAD, AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so REGISTRARS SHALL NOT RECEIVE A should be CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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