

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

74-9-17 25 1931

CERTIFICATE OF DEATH

1. PLACE OF BIRTH

County *Marion*  
Township *Boone*  
City *Boone*

Registration District No. *543*  
Primary Registration District No. *5734*

File No. *22079*  
Registered No. *5*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 26 - 1856*

7. AGE YEARS *75* MONTHS *9* DAYS *26* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, particular kind of work *Farmer*  
(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) *Indiana*

10. NAME OF FATHER

*Jacob Welch*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *U. S.*

12. MAIDEN NAME OF MOTHER

*Maggie Thompson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *U. S.*

14. INFORMANT

(Address) *Wm. H. Schoenfelder*  
*Boone*

15. FILED

*June 22 1931* *Emma Curtman*  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 15 1931*

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, and 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:

*Senility* *92A*  
*Dyslipidemia & Mitral* *137*  
*Insufficiency* *135*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

CONTRIBUTOR (SECONDARY)

*Enlarged Prostate*  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED

*Home*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

20. UNDERTAKER

21. DATE OF BURIAL

*St. Cecilia Cemetery* *June 18 1931*  
*H. H. Strop* *Boone*

\*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.)

# 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. 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, 8 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 origin; "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 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. 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 STATEMENT  
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 Marion

Registration District No. 543

Township Boss

Primary Registration District No. 5734

City Boss

(No.     )

File No. 5

Registered No. 0-

St.     

Ward     

**2. FULL NAME**

(a) Residence, No. James Buchanan Welsh

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)

Aug 26 - 1856

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1  
day, hrs.  
or min.

8. Trade, profession, or particular  
kind of work done, as spinner,  
sawyer, bookkeeper, etc.

9. Industry or business in which  
work was done, as silk mill,  
saw mill, bank, etc.

10. Date deceased last worked at  
this occupation (month and  
year)

11. Total time (years)  
spent in this  
occupation

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

Indiana

13. NAME

Jacob Welsh

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

15. MAIDEN NAME

Maggie Thompson

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

17. INFORMANT  
(ADDRESS)

Wm. H. Snyder

18. BURIAL, CREMATION, OR REMOVAL

Interred in cemetery DATE June 18, 1931

19. UNDERTAKER  
(ADDRESS)

H. H. Strop

20. FILED

June 22, 1931 Emma Curtman  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

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

June 15, 1931

22. I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1930, to June 15, 1931

I last saw him alive on June 15, 1931. Death is said  
to have occurred on the date stated above, at 8 p.m.

The principal cause of death and related causes of importance were as follows:

Senility  
cytosis mitral  
insufficiency

Other contributory causes of importance:

Enlarged Prostate

Date of onset

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?

Date of injury

Where did injury occur?

Home  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

S. E. Gaston

, M. D.

(Address)

Meta Mo.

Every item of information should be carefully supplied. AGE 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.

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

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