

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. See instructions on back of certificate.

1 PLACE OF DEATH

ARKANSAS STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

County Laclede 31697-a
Township Washington Registration District No. 449 File No. _____
Inc. Town or City _____ Primary Registration District No. 562 Registered No. _____
(No. _____ St.; _____ Ward)

2 FULL NAME Infant Gene Mr + Mrs Earl Hendrix
(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.

If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR or RACE W 5 Single, Married, Widowed, or Divorced (writes the word) ✓

16 DATE OF DEATH 9 / 10, 1931
Month Day Year

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

17 I HEREBY CERTIFY, That I attended deceased from 9-10 - 1931, to 9-10 - 1931, that I last saw him alive on 9-10 - 1931 and that death occurred, on the date stated above, at 4 a.m. The CAUSE OF DEATH* was as follows:
Premature birth

6 DATE OF BIRTH Sept 9, 1931
Month Day Year

(duration) 159 yrs. mos. ds.
159 / 5 9
(duration) _____ yrs. mos. ds.

7 AGE Years Month 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

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

9 BIRTHPLACE (city or town) Laclede Co (State or country)

18 Where was disease contracted? If not at place of death?

10 NAME OF FATHER Earl Hendrix

Did an operation precede death? No Date of _____
Was there an autopsy? No

11 BIRTHPLACE OF FATHER (city or town) Webster Co Mo (State or country)

What test confirmed diagnosis? (Signed) B C Bunnage M. D. 9-12-1931 (Address) Exeter Mo

12 MAIDEN NAME OF MOTHER Billie Allen
13 BIRTHPLACE OF MOTHER (city or town) Laclede Co Mo (State or country)

* 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.)

14 Informant Earl Hendrix (Address) Exeter Mo

19. PLACE OF BURIAL, CREMATION, or REMOVAL Catholic Cemetery DATE OF BURIAL 9/10 1931
20 UNDERTAKER ADDRESS

15 Filed _____, 1931 Registrar

Burial or Transit Permit issued by _____ Date of issue _____

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,"

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.—Certificates may 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, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus*.

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 Laclede Registration District No. 449 File No. _____
 Township Washington Primary Registration District No. 5612 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Hendrix (Infant)
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) _____
 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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♂ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 2-
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 9 - 1931
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min. 4

OCCUPATION
 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) mo -

MOTHER
 13. NAME Earl Hendrix

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

15. MAIDEN NAME Lillie

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

17. INFORMANT Earl Hendrix
 (ADDRESS) Stanway, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic Cem. DATE 9/10 1932

19. UNDERTAKER (ADDRESS) _____

20. FILED Jan 4, 1932 J M Bellinger
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 10 - 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Premature Birth
 Other contributory causes of importance: _____
 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 _____, 19____
 Where did injury occur? _____ (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) O. C. Benage, M. D.
 (Address) Conway, Mo.

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

S-31697^a

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