

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

Do not use this space.

1. PLACE OF DEATH

County Deer Registration District No. 1035
 Township Forest Primary Registration District No. 5371
 City Current (No.) St. Ward)

File No. 19985
 Registered No. 5

2. FULL NAME

Tom A. Halland
 (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 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 Mary O. Halland

6. DATE OF BIRTH (MONTH, DAY AND YEAR) sep 7 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 8 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or 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) Tenn
 (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)

PARENTS

14. INFORMANT (Address) J. A. Kinrock

15. FILED 6/25/34 J. A. Kinrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 1934

17. I HEREBY CERTIFY, That I attended deceased from May 1933 to Jan 24 1934 that I last saw him alive on Jan 17 1934 and that death occurred, on the date stated above, at 4/9 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13 my W
my W
 (duration) yrs. mos. da.
 CONTRIBUTOR arteriosclerotic
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ✓
 DID AN OPERATION PRECEDE DEATH? ✓ DATE OF ✓
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? ✓
 (Signed) Leslie Randall M. D.
626 1934 (Address) Licking 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 Mountaineer DATE OF BURIAL 6/25 1934

20. UNDERTAKER Wong ADDRESS

N. B.—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.

WRITE PLAINLY, WITH UNFADING INK

NOV 18 1934

United States Standard Certificate of Death

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

Statement of Occupation.—Precise statement of occupation is very important, so that the relative importance of various pursuits can be known. The same occupation 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 *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) *Seaman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Master," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Iron 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 should be indicated thus: *Farmer (retired)*, 6 for persons who have no occupation whatsoever, 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 accepted term for the same disease. Examples: *Epidemic 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., (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.; *Broncho-pneumonia* (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," "Infantion," "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 STATEMENTS BY PHYSICIAN.

#2 Deut.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

5 -

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Tom A. Holland

Who died at _____ on June - 24 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 66 Months 8 Days 13

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Mo

Birthplace of father (State or country) Mo Tenn

Birthplace of mother (State or country) Mo

Principal cause of death: Nephritis
Chronic (Long spell of sickness)

Other contributory causes of importance Arterial Sclerosis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? 131

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 _____

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

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 1035

Primary Reg. Dist. No. 5-3-71

E. T. McGaugh, M.D.

Special Agent. mk

58661-5

1101

SECRET