MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH SICIANS should state 1. PLACE OF DEATH Resistration District No..... Primary Registration District No..... Redistered No. (a) Besidence. (Usual place of abode) (If nonresident give city or town and State) Length of residence in city or town where death occurred How long in U.S., if of foreign birth? PERSONAL AND STATISTICAL PARTICULARS MEDICAL CERTIFICATE OF DEATH 3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR 16. DATE OF DEATH (MONTH, DAY AND YEAR) DIVORCED (write the word) statement HEREBY CERTIFY, That I attended deceased from ...... 5a. IF MARRIED, WIDOWED, OR DIVORCED 19.14 to June 19.15 HUSBAND OF (OR) WIFE OF 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7. AGE YEARS MONTHS DAYS If LESS then 1 day, .....hrs. Ъ or .....min. B. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work .... (b) General nature of industry, (SECONDAR business, or establishment in which employed (or employer) ......(duration),.....yrs. .....mes...... (c) Name of employer 18. WHERE WAS DISEASE CONTRACTED 9. BIRTHPLACE (CITY OR TOWN) ....... IF NOT AT PLACE OF DEATH?...... (STATE OR COUNTRY) DID AN OPERATION PRECEDE DEATHY NO DATE OF 10. NAME OF FATHER WAS THERE AN AUTOPSYT ...... YOU WHAT TEST CONFIRMED DIAGNOSIST plain (STATE OR COUNTRY) (Signed).... 12. MAIDEN NAME OF MOTHER , 19 -Every item of OF DEATH in \*State the Disease Causing Deate, of in deaths from Violent Causes, state 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)...... (1) MEANS AND NATURE OF INJURY, and (2) whether Accidental, Suicidal, or (STATE OR COUNTRY) HOMICHAL: (See reverse side for additional space.) 14. 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL INFORMANT ... (Address) 15.

## 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 '-- 'er statement; it should be used only when needed. examples: (a) Spinner, (b) Cotton mill; (a) Sales-1, (b) Grocery; (a) Foreman, (b) Automobile fac-. The material worked on may form part of the and statement. Never return "Laborer," "Foren," "Manager," "Dealer," etc., without more cise specification, as Day laborer, Farm laborer, borer-Goal 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," "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. VIOLENT DEATHS state MEANS OF INJURY and qualify AS ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OF AS probably such, if impossible to determine definitely. Examples: Accidental drowning; struck y railway train-accident; Revolver wound of headhomicide; 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.)

Nors.—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, crysipelas, 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.