

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

PLACE OF DEATH

County Shannon
Township Palmer
or
Village X
or
City X (NO. _____ St. _____ Ward _____)

Registration District No. 1086 File No. 30367
Primary Registration District No. 6677 Registered No. 9

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

FULL NAME Isaac Fard

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) X

DATE OF DEATH June 3 (Month) (Day) (Year) 1918

DATE OF BIRTH May 2 (Month) (Day) (Year) 1916

I HEREBY CERTIFY, that I attended deceased from X, 1918, to June 4, 1918, that I last saw him alive on June 3, 1918, and that death occurred, on the date stated above, at 5 P m.

AGE _____ yrs. 2 mos. 2 ds. If LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work X (b) General nature of industry, business, or establishment in which employed (or employer) Unknown

Unknown
2009
1891
(Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE (City or town, State or foreign country) Mo

Contributory X (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

NAME OF FATHER L. W. Lurie

(Signed) _____ M. D.

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

Aug 31, 1911 (Address) _____

MAIDEN NAME OF MOTHER Marie Hendricks

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death 16 yrs. 9 mos. 8 ds. In the State 16 yrs. _____ mos. _____ ds.

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

(Informant) L. W. Lurie

Former or usual residence Shannon Mo

(ADDRESS) Epiphany Mo

PLACE OF BURIAL OR REMOVAL Bowen Ave DATE OF BURIAL June 4, 1918

UNDERTAKER Isaac Fard ADDRESS Epiphany Mo

Filed Aug 31, 1918 J. E. Tripp REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state exactly supplied.

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, 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*, *Sar-*

coma, 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," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "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.)



MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
 County Shannon
 Township Bowling
 or
 Village _____
 or
 City _____

Registration District No. 1086 File No. 3
 Primary Registration District No. 6077 Registered No. 3
 (NO. _____ St. _____ Ward _____)

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

FULL NAME Levered Lane

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH May 2, 1911
 (Month) (Day) (Year)

AGE 2 yrs. 2 mos. 2 ds. If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Mo

PARENTS
 NAME OF FATHER C. M. Lane
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
 MAIDEN NAME OF MOTHER Francis Hendrick
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. Lane

(ADDRESS) Exchange Mo

Filed Oct 13 1911 M. J. Tripp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 3, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to June 4, 1911, that I last saw him alive on June 3, 1911, and that death occurred, on the date stated above, at 5 P m.
 The CAUSE OF DEATH* was as follows: Unknown

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. M. Lane M.D.
Aug 31 1911 (Address) Exchange Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place 3 yrs. _____ mos. _____ ds. In the State 13 yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Bowen Cem DATE OF BURIAL June 4 1911

UNDERTAKER Isaac Ford ADDRESS Exchange

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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