

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH
 County Moniteau
 Township Pilot Grove Registration District No. 577 File No. 1257
 or
 Village _____ Primary Registration District No. 5775 Registered No. _____
 or
 City _____ (NO. _____ St. _____ Ward _____) (If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME William E. Weedy

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>	DATE OF DEATH <u>Mar 30</u> , 191 <u>6</u> (Month) (Day) (Year)		
DATE OF BIRTH <u>June 29</u> , 18 <u>56</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Feb 1</u> , 191 <u>6</u> , to <u>Mar 31</u> , 191 <u>6</u>		
AGE <u>59</u> yrs. <u>9</u> mos. <u>1</u> ds.			that I last saw h <u>im</u> live on <u>Mar 30</u> , 191 <u>6</u> , and that death occurred, on the date stated above, at <u>109</u> m.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u>			The CAUSE OF DEATH* was as follows: <u>Uremic Poison</u> <u>120</u> <u>1223</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Farming</u>			(Duration) _____ yrs. <u>3</u> mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Ohio</u>			Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
PARENTS	NAME OF FATHER <u>Ulrich Weedy</u>		(Signed) <u>L. P. Patterson</u> M. D. <u>Apr 1</u> , 191 <u>6</u> (Address) <u>Lathrop</u>		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Switzerland</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	MAIDEN NAME OF MOTHER <u>Monia Lehman</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ohio</u>		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. E. Weedy</u>			Where was disease contracted if not at place of death? Former or usual residence _____		
(ADDRESS) <u>Lathrop Mo</u>			PLACE OF BURIAL OR REMOVAL <u>Bethel Cemetery</u>		DATE OF BURIAL <u>Apr 1</u> , 191 <u>6</u>
Filed <u>Apr 6</u> , 191 <u>6</u> <u>B-31-16</u>			REGISTRAR <u>L. P. Patterson</u>		ADDRESS <u>Lathrop Mo</u>

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 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 septichaemia," "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

1 PLACE OF DEATH

County

Moniteau
Pilot Grove

Township

or

Village

or

City

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

Registration District No.

511

File No.

Primary Registration District No.

5115

Registered No.

5

(NO.

St.

Ward)

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

2 FULL NAME

William E. Wetz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

M

6 DATE OF BIRTH

Satisfactory information supplied
(Month) (Day) (Year)

7 AGE

If LESS than
1 day.....hrs.
or.....min?
.....yrs.....mos.....ds.

8 OCCUPATION

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

9 BIRTHPLACE

(City or town,
State or foreign country)

PARENTS

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

3/31 1916 L L Laxhair
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar 30 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

191..... to 191.....

that I last saw him..... alive on 191.....

and that death occurred, on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Uraemic
Acute Nephritis

CONTRIBUTORY

(Secondary)

Duration)..... yrs..... mos..... ds.

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

(Signed) H W Laxhair M. D.

Apr 1 1916 (Address) Laxhair

*State the Disease Causing Death, or, in deaths from Violent Causes, state
(1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients,
or Recent Residents)At place
of death..... yrs..... mos..... ds. In the
State..... yrs..... mos..... ds.Where was disease contracted
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1916

20 UNDERTAKER

ADDRESS

Original file, date 1916, 19.....

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY INFORMATION SUPPLIED

Satisfactory information supplied

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