

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

PLACE OF DEATH

County Atchison

Township Torkio Twp

Village -

City - (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 20

File No. 788

Primary Registration District No. 414

Registered No. 8

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

FULL NAME Primitone birth - Point name of rubble

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH July 21, 1910  
(Month) (Day) (Year)

AGE 15<sup>7</sup>/<sub>8</sub> If LESS than 1 day, 3 hrs. or min.?  
yrs. mos. ds.

OCCUPATION (a) Trade, profession, or particular kind of work none 15<sup>7</sup>/<sub>8</sub>  
(b) General nature of industry, business, or establishment in which employed (or employer) - 15<sup>0</sup>/<sub>8</sub>

BIRTHPLACE (City or town, State or foreign country) Torkio Twp Atchison Co MO

PARENTS NAME OF FATHER Nelson H. Grubb BIRTHPLACE OF FATHER (City or town, State of foreign country) Mythe Co Va Mytheville MAIDEN NAME OF MOTHER Mary Walters BIRTHPLACE OF MOTHER (City or town, State of foreign country) Atchison Co MO Rock Port

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed 7/22 1910

REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 21, 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows:

Primitone birth - unable to take nourishment

lived & had duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. A. Postlewait M. D. July 21, 1910 (Address) Torkio 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 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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL South Cemetery near Rock Port Mo

DATE OF BURIAL July 22, 1910

UNDERTAKER r. c. Grant

ADDRESS Torkio MO

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.

THIS IS A PERMANENT RECORD

# 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, peritonaeum*, 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.)



PLACE OF DEATH

*Atchison*

County

*Larkio*

Township

or

Village

or

City

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

Registration-District No.

*20*

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

File No.

*788*

Primary Registration District No.

*1028*

Registered No.

*8*

(NO.

St.

Ward)

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

FULL NAME

*Premature birth - Parent named Shatt.*

PERSONAL AND STATISTICAL PARTICULARS

SEX *M.* COLOR OR RACE *W.* SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH *Febry 21, 1910*  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ 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) *Larkio Ind. Mo.*

PARENTS  
NAME OF FATHER *Melome H. G...  
BIRTHPLACE OF FATHER (City or town, State or foreign country) *Mythe Co. Mo.  
MAIDEN NAME OF MOTHER *Mary Walters  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Atchison Mo. Rock Port****

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed *Shas R. Safford* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Febry 21, 1910*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

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

The CAUSE OF DEATH\* was as follows:  
*Premature birth - unable to take nourishment*

lived *3 hrs.* (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) *J. A. Porttwait* M. D. *2/21, 1910* (Address) *Larkio, 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 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 \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL *near Rock Port, Mo.* DATE OF BURIAL *Feb. 22, 1910*

UNDERTAKER *H. C. Gont* ADDRESS *Larkio, Mo.*

*2/22/10* All information called for must be written on this Supplementary Certificate.

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.

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