

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.

PLACE OF DEATH

County Cape Girardeau  
 Township Apple Creek  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

120  
 Registration District No. 178 File No. 543  
 Primary Registration District No. 5176B Registered No. 1

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

FULL NAME Bascom Roberts

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>September 6<sup>th</sup></u> , 1898 (Month) (Day) (Year)		
AGE <u>12</u> yrs. <u>4</u> mos. <u>4</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>0</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Apple Creek sp. Near Daisy, Mo.</u>		
PARENTS	NAME OF FATHER <u>Thos B. Roberts</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Apple Creek sp. Near Daisy, Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Addie Limbaugh</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Apple Creek sp. Near Daisy, Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

3  
 DATE OF DEATH Jan 10, 1911  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from May 30<sup>th</sup>, 1910, to Jan 8, 1911,  
 that I last saw him alive on Jan 8<sup>th</sup>, 1911,  
 and that death occurred, on the date stated above, at 6<sup>15</sup> a.m.  
 The CAUSE OF DEATH\* was as follows:  
Nremia as a result of  
154 amyloid disease of the kidneys  
69A  
132B (Duration) \_\_\_ yrs. 6 mos. \_\_\_ ds.  
 Contributory Multiple osteomyelitis  
 (SECONDARY) (Duration) \_\_\_ yrs. 7 mos. 20 ds.  
 (Signed) N.A. Statter M. D.  
Jan 6, 1911 (Address) Oak Ridge, 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 \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) \_\_\_\_\_  
 (ADDRESS) \_\_\_\_\_  
 Filled Jan 10, 1911 H.B. Pittrell  
 REGISTRAR

PLACE OF BURIAL OR REMOVAL New Salem  
 DATE OF BURIAL 1/10, 1911  
 UNDERTAKER H.O. Williams  
 ADDRESS Oak Ridge, Mo

# 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, peritonacum*, 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.)



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PLACE OF DEATH

County Cape Girardeau  
 Township Apple Grove  
 or  
 Village \_\_\_\_\_  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

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

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

Registration District No. 128 File No. 343  
 Primary Registration District No. 5176 B Registered No. 1

FULL NAME Thomas Roberts

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

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE/MARRIED/WIDOWED/OR DIVORCED <u>Single</u> <small>(Write the word)</small>	DATE OF DEATH _____ 191 <u>1</u> <small>(Month) (Day) (Year)</small>	
DATE OF BIRTH <u>9/6</u> - <u>1898</u> <small>(Month) (Day) (Year)</small>			I HEREBY CERTIFY, that I attended deceased from <u>5/20</u> to <u>1/8</u> , 191 <u>1</u> , that I last saw him alive on <u>1/8</u> , 191 <u>1</u> , and that death occurred, on the date stated above, at <u>6:15 a.m.</u>	
AGE <u>12</u> yrs. <u>4</u> mos. <u>4</u> ds.			The CAUSE OF DEATH* was as follows: <u>Septicemia as a result of</u> <u>suppurated disease of the</u> <u>kidneys</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory (SECONDARY) <u>multiple osteomyelitis</u> <small>(Duration) _____ yrs. _____ mos. _____ ds.</small>	
BIRTHPLACE (City or town, State or foreign country) <u>Apple Grove, Mo.</u>			(Signed) <u>W. K. Statter</u> M. D. <u>1/6</u> , 191 <u>1</u> (Address) <u>Orange Mo.</u>	
PARENTS	NAME OF FATHER <u>Thos B. Roberts</u>		*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 FATHER (City or town, State or foreign country) <u>Apple Grove, Mo.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER <u>Addie Statter</u>		Where was disease contracted if not at place of death? _____	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Apple Grove, Mo.</u>		Former or usual residence _____	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Thos Roberts</u>			PLACE OF BURIAL OR REMOVAL <u>New Salem</u>	
(ADDRESS) <u>Daisy, MO</u>			DATE OF BURIAL <u>1/10</u> , 191 <u>1</u>	
Filed <u>Jan 10</u> X 191 <u>1</u> by <u>H B Futrell</u> REGISTRAR			UNDERTAKER <u>W O Williams</u>	
			ADDRESS <u>Cap. Ridge Mo</u>	

JAN 10.

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

# Revised United States Standard Certificate of Death

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

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