

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 Shelby  
 Township Black Creek  
 or  
 Village  
 or  
 City Shelbyville (NO. \_\_\_\_\_)

Registration District No. 831 File No. 4727  
 Primary Registration District No. 6092 Registered No. 3  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME Robert W Douglas

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH Jan 10, 1830  
 (Month) (Day) (Year)

AGE 81 yrs. 2 mos. 5 ds. If LESS than  
 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Retired Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) X 1-82

BIRTHPLACE (City or town, State or foreign country) Bath Co Va

PARENTS NAME OF FATHER Thos Douglas  
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Bath Co Va  
 MAIDEN NAME OF MOTHER Virginia Pullens  
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bath Co Va

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Wm Carson MD  
 (ADDRESS) Shelbyville Mo

Filed Jan 16 1911 W J Madril  
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 15, 1911  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 8<sup>th</sup>, 1911, to Jan 15, 1911, that I last saw him alive on Jan 15, 1911, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH\* was as follows:  
Double Lobar Pneumonia  
11A  
108

(Duration) X yrs. X mos. 7 ds.

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

(Signed) Wm Carson M. D.  
Jan 16, 1911 (Address) Shelbyville 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 ✓ DATE OF BURIAL ✓  
 \_\_\_\_\_ 1911

UNDERTAKER ✓ ADDRESS ✓

# 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 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.)



CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Shelby  
 Township Blount Creek  
 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. 831 File No. 4727  
 Primary Registration District No. 6092- Registered No. 3

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

FULL NAME Robert W. Douglas

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M-</u>	COLOR OR RACE <u>W-</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>1-10-</u> , 18 <u>30</u> (Month) (Day) (Year)		
AGE <u>81</u> yrs. <u>X</u> mos. <u>5</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>X</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Bath Co. Va.</u>		
PARENTS	NAME OF FATHER <u>Thos. Douglas</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Bath Co. Va.</u>	
	MAIDEN NAME OF MOTHER <u>Virginia Pullens</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Bath Co. Va.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
1-15-, 1911  
 (Month) (Day) (Year)  
 I HEREBY CERTIFY, that I attended deceased from 1-8, 1911, to 1-15-, 1911, that I last saw him alive on 1-15-, 1911, and that death occurred, on the date stated above, at 7P. m.  
 The CAUSE OF DEATH\* was as follows:  
Double Lobar Pneumonia

(Duration) \_\_\_ yrs. \_\_\_ mos. 7 ds.  
 Contributory La Grippe  
 (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
 (Signed) Wm. Carson M. D.  
1-16, 1911 (Address) Shelbyville, 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) Wm. Carson, M.D.  
 (ADDRESS) Shelbyville Mo.

Filed Jan 17, 1911, by Do. Mosdell REGISTRAR

PLACE OF BURIAL OR REMOVAL  
Shelbyville  
 UNDERTAKER  
Thompson  
 DATE OF BURIAL  
Jan 17, 1911  
 ADDRESS  
Shelbyville

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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