

PLACE OF DEATH

MISSOURI VITAL BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty HarrisonTownship Clay

Village _____

City _____ (NO _____ St.; _____ Ward)

Registration District No. 335-File No. 10199Primary Registration District No. 5470Registered No. 38

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

FULL NAME Otho F. Newton

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED Single WIDOWED OR DIVORCED (Write the word)DATE OF BIRTH March 27th, 1907
(Month) (Day) (Year)AGE 3 yrs. 11 mos. 24 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) 0BIRTHPLACE (City or town, State or foreign country) MOPARENTS NAME OF FATHER William NewtonBIRTHPLACE OF FATHER (City or town, State or foreign country) MOMAIDEN NAME OF MOTHER Jane OxfordBIRTHPLACE OF MOTHER (City or town, State or foreign country) MO

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Morgan(ADDRESS) Akron, MoFiled 3/23 1911 C. E. Odum REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 21, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Feb 26, 1911, to March 5, 1911, that I last saw him alive on March 14, 1911, and that death occurred, on the date stated above, at 10 P. M.The CAUSE OF DEATH* was as follows:
measles 7
10 P. M.

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

Contributory Broncho Pneumonia
(SECONDARY) (Duration) no yrs. no mos. 10 ds.(Signed) W. K. Wilong M. D.March 22 1911 (Address) St. Line 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 Four Corn. Gainesville DATE OF BURIAL 3/23 1911UNDERTAKER Norman Morgan ADDRESS Akron MONeighbors

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

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

PLACE OF DEATH

County.....
 Township..... Registration District No..... File No.....
 or Village..... Primary Registration District No..... 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

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month)....., 191....., 191.....	(Day)....., 191..... (Year)
AGEyrs.....mos.....ds.	IF LESS than 1 day,.....hrs. or.....min.?

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

BIRTHPLACE
 (City or town, State or foreign country)

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

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

(ADDRESS).....

Filed....., 191....., 191.....
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
 (Month)....., 191....., 191..... (Day)....., 191..... (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:

.....
 (Duration).....yrs.....mos.....ds.
 (Signed)..... (Address)..... M. D.
 (SECONDARY).....yrs.....mos.....ds.
 (Duration).....yrs.....mos.....ds.

Contributory
 (SECONDARY)

..... 191..... (Address)
 *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 REGENT 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
 191.....

UNDERTAKER
 ADDRESS

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

PLACE OF DEATH Navigation
County Clay
Township _____
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 335 File No. 10799
Primary Registration District No. 5470 Registered No. 33

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

FULL NAME Otho J. Newton

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 3/27, 1907
(Month) (Day) (Year)

AGE 3 yrs 11 mos. 24 ds.
If LESS than 1 day, hrs. or min. 2

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 William DeWitt

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

MAIDEN NAME OF MOTHER Jessie Oxford

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Morgan
(ADDRESS) Arkona Mo.

Filed 3/23 X 1911 F. M. Winniford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 3/21, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1911, to 3/5, 1911,
that I last saw him alive on 3/14, 1911,
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Measles.

(Duration) yrs. mos. 6 ds.

Contributory Throat Infection
(SECONDARY) (Duration) yrs. mos. 6 ds.

(Signed) W. B. DeLong M. D.
3/22, 1911 (Address) Sakona 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 _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Graveyard, Arkona DATE OF BURIAL 3/23, 1911

UNDERTAKER Neighbors ADDRESS Arkona, 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*, *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.)