

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

PLACE OF DEATH
County Howard
Township Prairie Registration District No. 376 File No. 10279
or
Village _____ Primary Registration District No. 58249 Registered No. _____
or
City Armstrong (NO. _____) St. _____ Ward _____
FULL NAME Infant [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>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>March 7, 1911</u> (Month) (Day) (Year)		AGE ____ yrs. ____ mos. <u>12</u> ds. If LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</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>Howard Co. Mo</u>		
PARENTS	NAME OF FATHER <u>Frankland M. Kerbey</u>	CONTRIBUTORY (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Howard Co Mo</u>	(Signed) <u>Frankland M. Kerbey</u> M. D. <u>Mon 20th, 1911</u> (Address) <u>Armstrong Mo.</u>
	MAIDEN NAME OF MOTHER <u>Miss. Grace Morrison</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 MOTHER (City or town, State or foreign country) <u>Howard Co.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

I HEREBY CERTIFY, that I attended deceased from Mar. 15th, 1911, to Mar. 17, 1911, that I last saw him alive on Mar. 15, 1911, and that death occurred, on the date stated above, at 6-54 m.
The CAUSE OF DEATH* was as follows:
Tuberculosis - followed or great-
ing in Convulsions 79A
6 86
(Duration) ____ yrs. ____ mos. 12 ds.

Where was disease contracted if not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL <u>Armstrong Cemetery</u>	DATE OF BURIAL <u>Mar 20th, 1911</u>
UNDERTAKER <u>Gates & Oldaker</u>	ADDRESS <u>Armstrong Mo.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. E. Gates
(ADDRESS) Armstrong Mo.

Filed 11 1911

REGISTRAR

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

N. B. - Every item of information should be carefully written.

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.)

HUGH STEPHENS, JEFFERSON CITY.



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 Howard
 Township Pravie
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

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

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

Registration District No. 376 File No. 10279
 Primary Registration District No. 55240 Registered No. _____

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

FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDDED OR DIVORCED (Write the word)
DATE OF BIRTH <u>March 7</u> , 19 <u>11</u> (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. <u>12</u> ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
March 19, 1911
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar. 15, 1911, to March 17, 1911, that I last saw him alive on Mar. 15, 1911, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:
Meningitis - followed or result
ing in Convulsions

BIRTHPLACE
(City or town, State or foreign country)
Howard Co. Mo.

PARENTS	NAME OF FATHER <u>Franklin M. Kidney</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Howard Co. Mo.</u>
	MAIDEN NAME OF MOTHER <u>Miss. Grace Merison</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Howard Co.</u>

(Duration) _____ yrs. _____ mos. 12 ds.

Contributory (SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Y. Sturme M. D.
Mar. 20, 1911 (Address) Armstrong 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) J. E. Gates
 (ADDRESS) Armstrong Mo.

PLACE OF BURIAL OR REMOVAL <u>Armstrong Cemetery</u>	DATE OF BURIAL <u>March 20</u> , 19 <u>11</u>
UNDERTAKER <u>Gates + Oldaker</u>	ADDRESS <u>Armstrong Mo.</u>

Filed wch 1911 H. S. Prinsley REGISTRAR

MAK 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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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.)