

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

PLACE OF DEATH
County Newton
Township Franklin
or
Village
or
City (NO. _____ St. _____ Ward _____)

Registration District No. 608 File No. 15141
Primary Registration District No. 5807A Registered No. _____

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

FULL NAME Leonard H Loney

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH Sept 10 1875
(Month) (Day) (Year)
AGE 36 yrs. 5 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work farmer
(b) General nature of industry business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Carole Ark

PARENTS
NAME OF FATHER William
BIRTHPLACE OF FATHER (City or town, State or foreign country) Peru Ind
MAIDEN NAME OF MOTHER Johnny Blood
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Peru Ind Ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L Loney
(ADDRESS) _____

Filed Apr 11 1911 L D Truman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 10th 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 17th 1911, to April 10th 1911, that I last saw him alive on April 10th 1911, and that death occurred, on the date stated above, at 3:30 p. m. The CAUSE OF DEATH* was as follows:

Septicemia
114 129 36
(Duration) yrs. mos. ds.

Contributory Abdominal Abscess
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) S Russell M. D.
4-10-1911 (Address) Fairview 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 Deer Cemetery DATE OF BURIAL 4-11 1911

UNDERTAKER Pogue & White ADDRESS Fairview

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.

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*, *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.



PLACE OF DEATH

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

County Worth Registration District No. 608 File No. _____
 Township Franklin or _____ Primary Registration District No. 3804 Registered No. _____
 Village _____ or _____ City _____ (NO. _____) (St. _____) (Ward _____)

FULL NAME Leonard H. Loney

[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 <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> OR DIVORCED <input type="checkbox"/> (If divorced, state date)	DATE OF DEATH <u>Sept 10</u> , 191 <u>1</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Sept 8</u> , 18 <u>70</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Sept 13</u> , 191 <u>1</u> , to <u>Sept 10</u> , 191 <u>1</u> , that I last saw him alive on <u>Sept 10</u> , 191 <u>1</u> , and that death occurred, on the date stated above, at <u>11:30</u> a.m.	
AGE <u>36</u> yrs. <u>5</u> mos. <u>5</u> ds.			IF LESS than 1 day, ___ hrs. or ___ min. <u>5</u> The CAUSE OF DEATH was as follows: <u>Septicemia</u>	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u>				
(b) General nature of industry, business, or establishment in which employed (of employer)				
BIRTHPLACE (City or town, State or foreign country) <u>Carroll, Ark.</u>				
PARENTS	NAME OF FATHER <u>William Loney</u>		Contributory (SECONDARY) <u>Abdominal Abscess</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Everett, Mo.</u>		Duration <u>4-10</u> yrs. mos. ds.	
	MAIDEN NAME OF MOTHER <u>S. Youngblood</u>		(Signed) <u>J. Russell</u> M.D.	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Franklin, Ark.</u>		<u>4-10</u> 191 <u>1</u> (Address) <u>Marion St.</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
(Informant) <u>Mrs. L. Loney</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
(ADDRESS) _____			At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
Filed <u>4-11</u> 191 <u>1</u>			Where was disease contracted if not at place of death? _____	
REGISTRAR <u>Wm. L. Loney</u>			Former or usual residence _____	
Original file, date <u>Apr 11</u> , 19 <u>11</u>			PLACE OF BURIAL OR REMOVAL <u>Reece Cem.</u>	
			DATE OF BURIAL <u>4-11</u> , 19 <u>11</u>	
			UNDERTAKER <u>Wm. L. Loney & Wm. L. Loney</u>	
			ADDRESS _____	

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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