

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

PLACE OF DEATH

County Wayne
Township St Francis
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 890 File No. 20149

Primary Registration District No. 6188 Registered No. 21

FULL NAME Thomas Gilbert

[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 Male COLOR OR RACE White SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH Dec. 3, 1892
(Month) (Day) (Year)
AGE 19 yrs. 5 mos. 27 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

DATE OF DEATH May 29, 1911
(Month) (Day) (Year)

OCCUPATION
(a) Trade, profession, or particular kind of work reg laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 3-07

I HEREBY CERTIFY, that I attended deceased from May 17, 1911, to May 29, 1911, that I last saw him alive on May 29, 1911, and that death occurred, on the date stated above, at 6-15 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

BIRTHPLACE
(City or town, State or foreign country) Beaver, Phelps Co Mo

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory Measles
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

PARENTS
NAME OF FATHER John Gilbert
BIRTHPLACE OF FATHER (City or town, State or foreign country) West Kansas
MAIDEN NAME OF MOTHER Mary Ann Jackson
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Phelps Co.

(Signed) _____ M. D.
1911 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Jackson
(ADDRESS) Princeton Mo

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 _____

Filed May 30, 1911 M. G. Wilson
REGISTRAR

PLACE OF BURIAL OR REMOVAL Oak Grove DATE OF BURIAL May 30, 1911
UNDERTAKER J. B. Layton ADDRESS Krome Ind

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, peritoneum*, 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.)



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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Wayne
Township St. Genevieve
or
Village _____
or
City _____ (NO. _____ St. _____ Ward)

Registration District No. 890 File No. 20749
Primary Registration District No. 6188 Registered No. 21

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

FULL NAME Thomas Gilbreath

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)
DATE OF BIRTH Dec. 3, 1892
(Month) (Day) (Year)
AGE 19 yrs. 5 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Beaver, Phelps Co. Mo
PARENTS NAME OF FATHER John Gilbreath BIRTHPLACE OF FATHER (City or town, State or foreign country) Beaver, Phelps Co. Mo
MAIDEN NAME OF MOTHER Nancy Ann Jackson BIRTHPLACE OF MOTHER (City or town, State or foreign country) Phelps Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Jackson
(ADDRESS) Greenville Mo
Filed July 9, 1911 J. G. Wilson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 29, 1911
(Month) (Day) (Year)
HEREBY CERTIFY, that I attended deceased from May 14, 1911, to May 29, 1911,
that I last saw him alive on May 29, 1911,
and that death occurred, on the date stated above, at 6:35 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. G. Wilson M. D.
May 29, 1911 (Address) Greenville 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 Oak Grove DATE OF BURIAL May 30, 1911
UNDERTAKER J. B. Layton ADDRESS Greenville Mo

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.)