

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

PLACE OF DEATH

County Bu

Township _____

or

Village _____

or

City Poplar Bluff (NO. _____ St.: _____ Ward)

Registration District No. 89

File No. 20444

Primary Registration District No. 3907

Registered No. 671

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

FULL NAME R. S. Kerkpatrick

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH June 17th, 1911
(Month) (Day) (Year)

DATE OF BIRTH don't know 1858
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him live on same day as he died.

AGE 52 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

and that death occurred, on the date stated above, at 12 m.

OCCUPATION Traveling man
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) H-O-B

The CAUSE OF DEATH* was as follows:

BIRTHPLACE Randolph Co
(City or town, State or foreign country) OK

Stomach Poisoning
177 (Duration) _____ yrs. _____ mos. _____ ds.

PARENTS
NAME OF FATHER J. K. Kerkpatrick
BIRTHPLACE OF FATHER Ill
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Sara Warren
BIRTHPLACE OF MOTHER Ala
(City or town, State or foreign country)

Contributory none
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Taylor County Mo M. D.
June 17th, 1911 (Address) Poplar Bluff

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. no

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Kerkpatrick
(ADDRESS) Soe hunters

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 June 17, 1911 W. P. Power REGISTRAR

PLACE OF BURIAL OR REMOVAL Spartan Ark DATE OF BURIAL June 17, 1911
UNDERTAKER Frank & W. Co ADDRESS Poplar Bluff

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.)



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

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

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Butler
Township _____
or
Village _____
or
City Poplar Bluff (NO. _____ St.: _____ Ward)

Registration District No. 89 File No. 20444

Primary Registration District No. 3007 Registered No. _____

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

FULL NAME R. S. Kirkpatrick

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF BIRTH don't know, 1858
(Month) (Day) (Year)

AGE 52 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Randolph Co Ark

PARENTS NAME OF FATHER J. N. Kirkpatrick BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill
MAIDEN NAME OF MOTHER Sarah BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ala

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

(ADDRESS) Pocahontas Ark

Filed 3/19 191____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 17, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred, on the date stated above, at 12 m. The CAUSE OF DEATH* was as follows:

Stomach Poison
due to eating Camp
regulator at Poplar Bluff
Ark
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) none 164
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. F. Taylor M. D. X
3/19, 1911 (Address) Poplar Bluff

*State the Disease Causing Death, or, in deaths from Violence, 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 Ark DATE OF BURIAL June 17, 1911

UNDERTAKER Frank L & A. C. ADDRESS P. O. Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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