

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

PLACE OF DEATH

County Saline

Township _____

or Village _____

or City Sweet Springs Mo.

Registration District No. 800

File No. 23254

Primary Registration District No. 4480

Registered No. 16

FULL NAME Benjamin Fraumeni Shanklin

[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 DEATH June 3rd, 1911
(Month) (Day) (Year)

DATE OF BIRTH Aug. 29, 1862
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 1, 1911, to June 3, 1911, that I last saw him alive on June 3, 1911, and that death occurred, on the date stated above, at 4:30 p.m.

AGE 48 yrs. 9 mos. 4 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:
Septicemia

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

1911 (Duration) 36 yrs. ___ mos. ___ ds.
Infected wound

BIRTHPLACE (City or town, State or foreign country) Jeramun Co Ky

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.
John H. Owens M. D.

NAME OF FATHER John H. Shanklin

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

MAIDEN NAME OF MOTHER Sarah L. Newman

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

(Signed) John H. Owens M. D. June 4, 1911 (Address) Sweet Springs Mo
*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) G. E. Shanklin

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.

(ADDRESS) Sweet Springs Mo

PLACE OF BURIAL OR REMOVAL Fairview Cemetery DATE OF BURIAL June 4, 1911

Filed June 3, 1911 J. H. Owens REGISTRAR

UNDERTAKER Herman Kenten ADDRESS Sweet Springs

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.)



County Saline Registration District No. 800 File No. 23254
 Township _____ or _____ Village _____ or _____ City Wined Springs (NO. _____ St.: _____ Ward _____)
 Primary Registration District No. 4480 Registered No. _____

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

FULL NAME Ben F. Shanklin

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
BEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH	
			<u>6/3</u> , 191 <u>7</u> (Month) (Day) (Year)	
DATE OF BIRTH			I HEREBY CERTIFY, that I attended deceased from	
(Month) _____ (Day) _____ (Year) _____			_____ , 191____, to _____ , 191____,	
AGE			that I last saw h_____ alive on _____ , 191____,	
IF LESS than _____ 1 day, _____ hrs _____ or _____ min.?			and that death occurred, on the date stated above, at _____ m.	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			The CAUSE OF DEATH* was as follows: <u>Wound - accidental</u> <u>scratch on hand -</u> <u>Syphilis</u>	
BIRTHPLACE (City or town, State or foreign country)			(Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	NAME OF FATHER		Contributory _____ (SECONDARY)	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)		(Duration) _____ yrs. _____ mos. _____ ds.	
	MAIDEN NAME OF MOTHER		(Signed) <u>Frank Query</u> M. D. <u>Mich. 16</u> 191 <u>7</u> (Address) <u>Smith St. J. Mo.</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)		*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) _____ (ADDRESS) _____			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 _____ 191____			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____	
REGISTRAR _____			UNDERTAKER _____ ADDRESS _____	

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