

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

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

PLACE OF DEATH  
County Saline  
Township Marshall  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

Registration District No. 796 File No. 26962  
Primary Registration District No. 6039 Registered No. 58  
(No. County farm St.: \_\_\_\_\_ Ward)

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

FULL NAME Bartholomew G. Garnett

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>widowed</u> (Write the word)
DATE OF BIRTH <u>Not known</u> (Month) (Day) (Year)		
AGE <u>about 68</u> yrs. mos. ds.		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Horse Business</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Virginia</u>		
PARENTS	NAME OF FATHER <u>Not known</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>" "</u>	
	MAIDEN NAME OF MOTHER <u>" "</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>" "</u>	

MEDICAL CERTIFICATE OF DEATH
DATE OF DEATH <u>July 6, 1911</u> (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from <u>July 12</u> , 191 <u>0</u> , to <u>July 5</u> , 191 <u>1</u> , that I last saw him alive on <u>July 5</u> , 191 <u>1</u> , and that death occurred, on the date stated above, at <u>5:30</u> m.
The CAUSE OF DEATH* was as follows: <u>6 cancer</u>
Contributory (SECONDARY) <u>Syphilis</u> (Duration) <u>1 1/2</u> yrs. mos. ds.
(Signed) <u>B. M. Spotts</u> M. D. <u>July 5, 1911</u> (Address) <u>Marshall Mo.</u>
*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) W. N. Wilson

(ADDRESS) Marshall R. P. 69th  
Filed July 6, 1911 Al. Putnam REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>County farm</u>	DATE OF BURIAL <u>July 6, 1911</u>
UNDERTAKER <u>P. M. Walker</u>	ADDRESS <u>Marshall</u>

# 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.

PLACE OF DEATH

County Saline  
Township Marshall  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_

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

Registration District No. 796 File No. 26967

Primary Registration District No. 6039 Registered No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

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

FULL NAME

Larsin Garnett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX \_\_\_\_\_ COLOR OR RACE \_\_\_\_\_  
SINGLE MARRIED WIDOWED OR DIVORCED  
(Write the word)

DATE OF DEATH \_\_\_\_\_, 191\_\_\_\_  
(Month) 7/5 (Day) (Year)

DATE OF BIRTH \_\_\_\_\_, 1\_\_\_\_  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

AGE \_\_\_\_\_  
If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?  
\_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_,  
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:

BIRTHPLACE  
(City or town, State or foreign country) \_\_\_\_\_

Cancer of Left Breast  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) B M Apathe M. D.  
\_\_\_\_\_, 191\_\_\_\_ (Address) Marshall 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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_

REGISTRAR

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY

B M Apathe Marshall

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