

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

PLACE OF DEATH

County Lolay
Township Gallatin
or
Village Hampton
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 199 File No. 27745
Primary Registration District No. 5276 Registered No. 26

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

FULL NAME Richard Bernal

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>April 26, 1911</u> (Month) (Day) (Year)		
AGE <u>4 yrs. 4 mos. ds.</u>		IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country) <u>Clinton Co MO</u>		
PARENTS	NAME OF FATHER <u>John Bernal</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Platt Co MO</u>	
	MAIDEN NAME OF MOTHER <u>May Jordan</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Platt Co M.</u>	

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Aug 19, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1911, to Aug 19, 1911, that I last saw him alive on Aug 19, 1911, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Innervation

158 (Duration) yrs. 1 mos. ds.

Contributory
(SECONDARY) _____ (Duration) yrs. mos. ds.

(Signed) W. M. Dagg M. D.
Aug 7, 1911 (Address) Hampton

*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 <u>Platt City</u>	DATE OF BURIAL <u>Aug 20, 1911</u>
UNDERTAKER <u>none</u>	ADDRESS _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Dagg
(ADDRESS) Hampton
Filed 8/30 1911 W. J. French
REGISTRAR

REPRODUCED FROM ORIGINAL RECORDS. PHOTOCOPIES SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

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

PLACE OF DEATH

County _____
 Township _____ or _____
 Village _____
 City _____ (NO. _____)
 Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St.: _____ Ward _____
 [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
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DATE OF BIRTH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

AGE _____ yrs., _____ mos., _____ ds. or _____ hrs. _____ min.?

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

BIRTHPLACE
 (City or town, State or foreign country) _____

NAME OF FATHER _____

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

MAIDEN NAME OF MOTHER _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____, 191____ (Year) _____

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

(Duration) _____ yrs. _____ mos. _____ ds.

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ 191____ (Address) _____ M. D.

*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** _____

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 Clay, Callahan Registration District No. 197 File No. Primary Registration District No. 5246 Registered No. 26. City (NO. St. Ward)

FULL NAME

Richard Hencel?

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Apr. 26, 1911 (Month) (Day) (Year)

AGE 4 yrs. 4 mos. 10 ds. IF LESS than 1 day, hrs. or min.

OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Chariton, Mo.

NAME OF FATHER H. M. Hencel?

BIRTHPLACE OF FATHER (City or town, State or foreign country) Platte Co. Mo.

MAIDEN NAME OF MOTHER B. J. Gordon

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Platte Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Dagg

(ADDRESS) Salem

Filed Oct 16 X 1911. I of Ward X REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 19, 1911 (Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Aug 1, 1911, to Aug 19, 1911, that I last saw him alive on Aug 19, 1911, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: General Infection

(Duration) 5 yrs. 5 mos. ds.

Contributory (Secondary) Whooping Cough

(Signed) A. M. Dagg M. D. 7-7 1911 (Address) Salem

*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 Platte City DATE OF BURIAL Aug 19, 1911

UNDERTAKER none ADDRESS

Original file date Aug 8/130 1911

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

Property transferred. 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.)

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