

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.

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

PLACE OF DEATH Country
 County Wilder Registration District No. 314 File No. 27983-1
 Township _____ or _____ Village _____ Primary Registration District No. 5433 Registered No. 32
 City _____ (NO. 3) St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME David Gabriel

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Married MARRIED Widowed OR DIVORCED (Write the word)
 DATE OF BIRTH Aug 24, 1826 (Month) (Day) (Year)
 AGE 84 yrs. 9 mos. 25 ds. If LESS than 1 day, ___ hrs. or ___ min.?
 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) Willingboro Mo.
 BIRTHPLACE (City or town, State or foreign country) Morgan Co. Mo.
 NAME OF FATHER Abraham Gabriel
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Penn
 MAIDEN NAME OF MOTHER Sarah D. H. H. H.
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 19, 1911 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Aug 18, 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 9 30 a. m.
 The CAUSE OF DEATH was as follows:
Mitral insufficiency
4 40
 (Duration) ___ yrs. ___ mos. ___ ds.
 Contributory Cancer (Duration) ___ yrs. ___ mos. ___ ds.
 (Signed) L. H. Williamson M. D. (Address) Country Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) David Gabriel
 (ADDRESS) Country Mo.
 Filed Aug 21, 1911 C. W. McCarlin REGISTRAR

*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 Jennings Cemetery DATE OF BURIAL Aug 21, 1911
 UNDERTAKER John Bennington ADDRESS Stanhurst Mo.

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.)

HUGH STEPHENS, JEFFERSON CITY.



Exact statement of OCCUPATION in very important.

PLACE OF DEATH

County Gentry
Township Wilson
or
Village
or
City (NO.)

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

Registration District No. 314 File No.
Primary Registration District No. 5433 Registered No. 32
St.: Ward)

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

FULL NAME David Gabriel

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>widowed</u>
DATE OF BIRTH <u>Oct. 24</u> , 18 <u>26</u> (Month) (Day) (Year)		
AGE <u>84</u> yrs. <u>9</u> mos. <u>25</u> 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>Tilling the soil.</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Morgan Co. Mo.</u>		
PARENTS	NAME OF FATHER <u>Abraham Gabriel</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Penn.</u>	
	MAIDEN NAME OF MOTHER <u>Sarah (Don't know the other)</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky.</u>	

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Aug. 18, 1911, to Aug. 19, 1911, that I last saw him alive on ", 1911, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) ___ yrs. ___ mos. 4 ds.
Contributory Cancer Right Ear
(SECONDARY) (Duration) 13 yrs. ___ mos. ___ ds.
(Signed) L. N. Williamson M. D.
Aug. 20, 1911 (Address) Gentry 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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Gabriel
(ADDRESS) Gentry Mo.
Filed Aug 21, 1911 L. H. M. ... REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Jennings Cemetery</u>	DATE OF BURIAL <u>Aug. 21</u> , 19 <u>11</u>
UNDERTAKER <u>John Pennington</u>	ADDRESS <u>Stanberry Mo</u>

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.)