

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

PLACE OF DEATH

County Lafayette
Township Clay
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 463 File No. 28697
Primary Registration District No. 5622B Registered No. _____

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

FULL NAME Edward Russell Ellis

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Aug 15, 1911
(Month) (Day) (Year)

DATE OF BIRTH Aug 14, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 14, 1911, to Aug 15, 1911, that I last saw him alive on Aug 15, 1911, and that death occurred, on the date stated above, at 4 P m.

AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
yrs. _____ mos. 2 ds.

THE CAUSE OF DEATH* was as follows:

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

Meningitis - Traumatic

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

13 (Duration) yrs. mos. ds.

NAME OF FATHER Samuel Teal Ellis

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

BIRTHPLACE OF FATHER (City or town, State or foreign country) Prussia Home, Mo.

(Signed) F.C. Barber M. D.
Aug 15, 1911 (Address) Napoleon Mo

MAIDEN NAME OF MOTHER Mabel Genevieve North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Informant) Samuel Teal Ellis

Where was disease contracted if not at place of death? _____

(ADDRESS) Napoleon Mo

Former or usual residence _____

Filed Aug 15, 1911 F.C. Barber

PLACE OF BURIAL OR REMOVAL Prussia Home Mo DATE OF BURIAL Aug 16, 1911

REGISTRAR

UNDERTAKER H.K. Ellis ADDRESS Prussia Home Mo

Care of Cemetery

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.)



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

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CERTIFICATE OF DEATH

PLACE OF DEATH
County Lafayette
Township Blay
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 463 File No. 28697
Primary Registration District No. 3677B Registered No. _____

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

FULL NAME Edw. P. Ellis

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____, 191____ (Month) (Day) (Year)		
AGE _____ yrs. _____ mos. _____ ds.		if LESS than 1 day, _____ hrs. or _____ 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) _____		
PARENTS	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) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 8-15, 1911
(Month) (Day) (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:
Strammatom

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

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

(Signed) _____ M. D.

_____ 191____ (Address) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____

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 _____	DATE OF BURIAL _____ 191____
UNDERTAKER _____	ADDRESS _____

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

Original file. date _____, 19____

Revised United States Standard Certificate of Death

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