

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

PLACE OF DEATH

County Monroe  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Versailles (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 598

File No. 32101

Primary Registration District No. 4355 598

Registered No. 41

FULL NAME

John Perry Sullens

[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

COLOR OR RACE

SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)

male

white

widowed

DATE OF DEATH

Sept 28, 1911  
(Month) (Day) (Year)

DATE OF BIRTH

April 19<sup>th</sup>, 1887  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 14, 1911, to Sept 28, 1911, that I last saw him alive on Sept 28, 1911, and that death occurred, on the date stated above, at 11 P.M.

AGE

85 yrs. 5 mos. 9 ds.

IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

Fracture of hip joint

OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) X

BIRTHPLACE

(City or town, State or foreign country) Franklin Co., Mo.

(Duration) \_\_\_ yrs. \_\_\_ mos. 14 ds.

Contributory Chronic bronchitis

NAME OF FATHER

David Sullens

(Duration) 30 yrs. \_\_\_ mos. \_\_\_ ds.

(Signed) A. J. Gunn M. D.

BIRTHPLACE OF FATHER

Tennessee

(Address) Versailles Mo

MAIDEN NAME OF MOTHER

Not known

\*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

Not known

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

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Sullens

Where was disease contracted If not at place of death?

Former or usual residence

(ADDRESS) Jackson, Miss.

PLACE OF BURIAL OR REMOVAL

Versailles, Mo.

DATE OF BURIAL

Sept 29, 1911

Filed

Sep 29, 1911, J. M. Lutzman

REGISTRAR

UNDERTAKER

Al. Kidwell

ADDRESS

Versailles

Mo.

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.)



## PLACE OF DEATH

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

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

 County \_\_\_\_\_  
 Township \_\_\_\_\_ or Village \_\_\_\_\_ or City Versailles (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 Registration District No. 598 File No. 32101  
 Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

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

## FULL NAME

Mr. Perry Sullivan

## PERSONAL AND STATISTICAL PARTICULARS

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

 DATE OF BIRTH \_\_\_\_\_, \_\_\_\_\_, 19\_\_\_\_  
 (Month) (Day) (Year)

 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 If LESS than 1 day, \_\_\_\_\_ 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)

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

Filed \_\_\_\_\_, 19\_\_\_\_

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

 DATE OF DEATH \_\_\_\_\_, 19\_\_\_\_  
 (Month) (Day) (Year)

 I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred, on the \_\_\_\_\_ above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Fracture  
accidental  
due to fall.

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

Contributory \_\_\_\_\_

(SECONDARY)

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

 (Signed) A. J. Gunn M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address) Versailles 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

19\_\_\_\_

UNDERTAKER

ADDRESS

SUPPLEMENTARY

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

Original file, date \_\_\_\_\_, 19\_\_\_\_

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

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