

## PLACE OF DEATH

County Marion  
 Township Jackson  
 or  
 Village  
 or  
 City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

 MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH
Registration District No. 542File No. 35209Primary Registration District No. 5731Registered No. 37

FULL NAME

Thomas Fletcher Branson

(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

White
 SINGLE  
 MARRIED  
 WIDOWED  
 OR DIVORCED  
 (Write the word)

DATE OF BIRTH

Sept 28, 1964  
 (Month) (Day) (Year)

AGE

47 yrs. = 28 mos. 28 ds.  
 or 1 day, hrs. min.?

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

OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer & Dr.

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

Stock Dealer

BIRTHPLACE

(City or town, State or foreign country)

Marion Co, Mo

PARENTS

NAME OF FATHER

William G. Branson

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Marionade Co Mo

MAIDEN NAME OF MOTHER

Martha A. Finney

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Marionade Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Branson(ADDRESS) Weldon MoFiled 10/21, 1964, T. S. Mcgee

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Oct 20, 1964  
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept. 19, 1964, to Oct 20, 1964, that I last saw him alive on Oct 20, 1964, and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Myocardial Infarction followed by Peritonitis
12? (Duration) hrs. mos. ds.

Contributory

(SECONDARY)

(Duration) hrs. mos. ds.

(Signed)

Oct 29, 1964 (Address) Vienna Mo 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 hrs. mos. ds. In the State hrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Vienna Cemetery 10/22, 1964

UNDERTAKER

Wm Mc Keefer Vienna Mo

DATE OF BURIAL

ADDRESS

# 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 surgi cal 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.)



RECORD OF OCCUPATION IS VERY IMPORTANT.

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 *Maries*  
Township *Jackson*  
or  
Village  
or  
City (NO. St. Ward)

Registration District No. *542*  
Primary Registration District No. *5-731*

File No.  
Registered No. *37*

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

FULL NAME *Thomas Fletcher Bronson*

PERSONAL AND STATISTICAL PARTICULARS

SEX *male* COLOR OR RACE *white* SINGLE MARRIED *Married*  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH *Sept 28, 1864*  
(Month) (Day) (Year)

AGE *47* yrs. *22* mos. *22* 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) *stock dealer*

BIRTHPLACE (City or town, State or foreign country) *Maries Co. Mo.*

PARENTS  
NAME OF FATHER *William B. Bronson*  
BIRTHPLACE OF FATHER *Marion Co. Mo.*  
(City or town, State or foreign country)  
MAIDEN NAME OF MOTHER *Rebecca Finn*  
BIRTHPLACE OF MOTHER *Tenn.*  
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *B. F. Bronson*  
(ADDRESS) *Wildon Mo.*

Filled *10/21/1911* *P. S. McGehee*  
REGISTRAR

Original file, date *Oct 21*, 19*11*

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Oct 20, 1911*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Sept 19, 1911*, to *Oct 20, 1911*, that I last saw him alive on *Oct 20, 1911*, and that death occurred, on the date stated above, at *1 P. m.*

The CAUSE OF DEATH\* was as follows:  
*Syphoid Fever followed by Peritonitis*

Contributory (SECONDARY)

(Duration) yrs. *1* mos. *1* ds.

(Signed) *J. E. Rose* M. D.  
*Oct 29, 1911* (Address) *Vernon 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 *Vernon Cem* DATE OF BURIAL *10/27/1911*

UNDERTAKER *Wm McKeever* ADDRESS *Vernon Mo.*

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

# 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.)

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