

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
County Butler
Township neely Registration District No. 88 File No. 2
or Village neelyville Primary Registration District No. 5130 Registered No. 8
or City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME William McNatt.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Man.</u>	COLOR OR RACE <u>White.</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single.</u> (Write the word)	DATE OF DEATH <u>January 28</u> , 19 <u>12</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>June 1</u> , 18 <u>82</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>January 22</u> , 19 <u>12</u> , to <u>January 28</u> , 19 <u>12</u> , that I last saw him alive on <u>January 27</u> , 19 <u>12</u> , and that death occurred, on the date stated above, at <u>4 A. m.</u> The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia Fever</u>	
AGE <u>29</u> yrs. <u>8</u> mos. <u>28</u> ds. IF LESS than 1 day, ___ hrs. or ___ min.?			108 194 1/2 (Duration) <u>X</u> yrs. <u>X</u> mos. <u>7</u> ds.	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm labor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>XX 1 = 0 2 =</u>			Contributory <u>exposure.</u> (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.	
BIRTHPLACE (City or town, State or foreign country) <u>Near moark clay Co. ARK</u>			(Signed) <u>W. E. Nantaise</u> M. D. <u>Jan 29</u> , 19 <u>12</u> (Address) <u>Moark</u>	
PARENTS	NAME OF FATHER <u>James McNatt.</u>		*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 FATHER (City or town, State or foreign country) <u>unknown</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. <u>7</u> ds. In the State ___ yrs. ___ mos. ___ ds. <u>All of his life</u>	
	MAIDEN NAME OF MOTHER <u>Eliza Johnson.</u>		Where was disease contracted if not at place of death? <u>Same Place.</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>unknown</u>		Former or usual residence <u>Same when he died</u>	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo W Moss.</u> (ADDRESS) <u>Neelyville. Mo,</u>			PLACE OF BURIAL OR REMOVAL <u>Roberts cemetary</u> DATE OF BURIAL <u>Jan 29</u> , 19 <u>12</u>	
Filed <u>January 29</u> , 19 <u>12</u> , <u>W. B. Davis</u> REGISTRAR			UNDERTAKER <u>G. W. Moss</u> ADDRESS <u>Neelyville</u>	

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*, *Compositor*, *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.)



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County Butler
 Township Neely
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 Registration District No. 88 File No. 2308
 Primary Registration District No. 5130 Registered No. 0

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

FULL NAME William Mc Nat

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(Write the word)

DATE OF BIRTH June 1, 1882
(Month) (Day) (Year)

AGE 29 yrs. 8 mos. 28 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE Near Mark Clay Co. Va
(City or town, State or foreign country)

PARENTS
 NAME OF FATHER James Mc Nat
 BIRTHPLACE OF FATHER _____
(City or town, State or foreign country)
 MAIDEN NAME OF MOTHER Eliza Johnson
 BIRTHPLACE OF MOTHER W. Va
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. W. Moss X
 (ADDRESS) Neelyville Mo

Filed January 27, 1912 by W. B. Davis X
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 28, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 22, 1912, to Jan 28, 1912, that I last saw him alive on Jan 27, 1912, and that death occurred, on the date stated above, at 4 1/2 m.
 The CAUSE OF DEATH* was as follows:

Lobar pneumonia
fever

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (SECONDARY) exposure
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W. E. Hamilton M. D.
Jan 29, 1912 (Address) Mark

*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. 7 ds. In the all life State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? same place
 Former or usual residence " " "

PLACE OF BURIAL OR REMOVAL Roberts Cem DATE OF BURIAL Jan 29, 1912
 UNDERTAKER G. W. Moss ADDRESS Neelyville Mo

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

JAN

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