

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 Dunklin
County Holcomb
Township _____ or Village _____ or City _____ (NO. _____ St. _____ Ward _____)
Registration District No. 286 File No. 759
Primary Registration District No. 5404 Registered No. 23
FULL NAME Chas E Tubbs (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 married (Write the word)
DATE OF BIRTH Nov 2, 1876 (Month) (Day) (Year)
AGE 36 yrs. 2 mos. 2 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) none
BIRTHPLACE (City or town, State or foreign country) Tennessee
PARENTS
NAME OF FATHER Not known
BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known
MAIDEN NAME OF MOTHER Not known
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not known

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 1, 1912 (Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from 10 25, 1911, to Jan 1, 1912, that I last saw him alive on Jan 1, 1912, and that death occurred, on the date stated above, at 10 9 p. The CAUSE OF DEATH* was as follows:
Old man moribund
108
10607
(Duration) ____ yrs. ____ mos. 10 ds.
Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Wm W. H. H. H. M. D. (Address) Holcomb 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 ____ 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) Ed Chaser
(ADDRESS) Gibson mo
Filed Jan 10 1912 R. H. Hogue Deputy REGISTRAR

PLACE OF BURIAL OR REMOVAL Canon Cerr DATE OF BURIAL _____ 1912
UNDERTAKER Marrs & Powell ADDRESS Holcomb 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*, *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 Dunklin
 Township Holcomb
 or
 Village _____
 or
 City _____ (NO. _____)

REGISTRARS SHALL NOT RE-
 CEIVE A FEE FOR CERTIFICATES
 UNTIL THEY ARE COMPLETED AS
 PRESCRIBED BY LAW.
 Registration District No. 286
 Primary Registration District No. 5404

File No. 759
 Registered No. 23

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

FULL NAME

Chas E. Tubbs

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>married</u> (If write the word)
DATE OF BIRTH <u>Nov 2</u> , 1876 (Month) (Day) (Year)		
AGE <u>36</u> yrs. <u>2</u> mos. <u>2</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)		
BIRTHPLACE (City or town, State or foreign country) <u>Sumner</u>		
PARENTS	NAME OF FATHER <u>Mr. Tubbs</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Sumner</u>	
	MAIDEN NAME OF MOTHER <u>Sumner</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Sumner</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
Jan 1, 1912
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Dec 28, 1911, to Jan 8, 1912,
 that I last saw live on Jan 8, 1912,
 and that death occurred, on the date stated above, at 10 a.m.
 The CAUSE OF DEATH was as follows:
Lobar Pneumonia

Contributory (SECONDARY)
Coronitis
 (Duration) ___ yrs. ___ mos. 10 ds.

(Signed) Jan 15, 1912 (Address) Holcomb M. D.
John W. Shaffer

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
No

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) Ed Shaser
 (ADDRESS) Gibson No

Filed Jan 17, 1912 R. H. Higgins DEPUTY REGISTRAR

PLACE OF BURIAL OR REMOVAL
Carroll Ave

DATE OF BURIAL
Jan 16, 1912

UNDERWRITER
Morris & Powell

ADDRESS
Holcomb

JAN

All information called for must be written on this Supplementary Certificate. No

Revised United States Standard Certificate of Death

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

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