

## PLACE OF DEATH

County BooneTownship Cedar

Village \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_)

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATHRegistration District No. 71File No. 4176Primary Registration District No. 5110aRegistered No. 8

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

FULL NAME Robert Emory Sapp

## PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Single</u> (Write the word)
DATE OF BIRTH <u>Mar - 3 1886</u> (Month) (Day) (Year)		
AGE <u>25 yrs. 11 mos. 6 ds.</u>		IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION  
(a) Trade, profession, or particular kind of work Farming(b) General nature of industry, business, or establishment in which employed (or employer) 1-02BIRTHPLACE  
(City or town, State or foreign country) Mo.NAME OF FATHER Eddie SappBIRTHPLACE OF FATHER  
(City or town, State or foreign country) MoMAIDEN NAME OF MOTHER Lella SmithBIRTHPLACE OF MOTHER  
(City or town, State or foreign country) Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C Sapp(ADDRESS) AshlandFiled Feb 21 1912 A. Nichols

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 21 1912  
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Feb 19 1912, to Feb 21 1912, that I last saw him alive on Feb 21 1912, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH\* was as follows:

Inflammation of Brain  
194K.Contributory Fracture Internal ear  
(SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 2 ds.(Signed) A. Nichols M. D.  
2/21 1912 (Address) A. Nichols

\*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 LibertyDATE OF BURIAL 2/22 1912UNDERTAKER B. J. M. G.ADDRESS Ashland

# 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.)

HUGH STEPHENS, JEFFERSON CITY.



PLACE OF DEATH

County Boone  
Township Cedar  
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. 71 File No. \_\_\_\_\_

Primary Registration District No. 5110A Registered No. 8

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

FULL NAME

Robey Emory Sapp.

PERSONAL AND STATISTICAL PARTICULARS

SEX m. COLOR OR RACE w. SINGLE MARRIED WIDOWED OR DIVORCED S.  
(Write the word)

DATE OF BIRTH mch. 3, 1886  
(Month) (Day) (Year)

AGE 25 yrs. 11 mos. 6 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

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

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

NAME OF FATHER Eddie Sapp.

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

MAIDEN NAME OF MOTHER Zeola Smart

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Sapp

(ADDRESS) Ashland

Filed Feb 21 1912 A. Nichols REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb. 21, 1912  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 19, 1912, to Feb. 21, 1912, that I last saw him alive on \_\_\_\_\_, 1912, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH\* was as follows:  
Inflammation of Brain  
Cause by falls,  
of tree while logging  
accidental (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

Contributory fracture internal ear (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

(Signed) \_\_\_\_\_ M. D.  
\_\_\_\_\_, 1912 (Address)

\*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 Liberty DATE OF BURIAL 2/22, 1912

UNDERTAKER B. J. M. Co ADDRESS Ashland

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

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. AGE should be stated. PERMANENT RECORD properly classified. Exact statement of age.

Supplemental

# Revised United States Standard Certificate of Death

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*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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