

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 Audrain
Township Wilson
or
Village Lempson
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 95A File No. 8084
Primary Registration District No. 5037B Registered No. _____

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

FULL NAME O. H. Neal

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED
(Write the word)

DATE OF BIRTH

X _____, X _____, 1887
(Month) (Day) (Year)

AGE

61 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION

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

BIRTHPLACE

(City or town, State or foreign country) Virginia

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) A. J. Sant(ADDRESS) Thompson MoFiled Mar 18 1912, M J Dodd

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

March 18, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 9, 1912, to March 18, 1912; that I last saw him alive on March 18, 1912, and that death occurred, on the date stated above, at 9:45 m.

The CAUSE OF DEATH* was as follows:

Paralysis following
Phlebotomy
10%

82.00 (Duration) _____ yrs. 1 mos. 7 ds.

Contributory (SECONDARY)

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

(Signed) R. V. Phelps

M. D.

8-14 1912 (Address) Mexico 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

Thompson Mo

DATE OF BURIAL

3/19 1912

UNDERTAKER

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 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.)



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

PLACE OF DEATH
County Audrain
Township Wilson
or
Village
or
City

Registration District No. 956 File No. 8084
Primary Registration District No. 5037B Registered No. 1
St. Ward

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

FULL NAME O. H. Neal

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX <u>m.</u>	COLOR OR RACE <u>w.</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>m.</u>
DATE OF BIRTH <u>1857</u> (Month) (Day) (Year)		
AGE <u>61</u> yrs. mos. ds.		IF LESS than 1 day, hrs. or min.

DATE OF DEATH Mar. 18, 1912
(Month) (Day) (Year)
I HEREBY CERTIFY, that I attended deceased from Mar. 9, 1912, to Mar. 18, 1912,
that I last saw h. alive on Mar. 9, 1912,
and that death occurred, on the date stated above, at 9:15 P.M.

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

The CAUSE OF DEATH* was as follows:
Paralysis, following Pneumonia.
Lobar

BIRTHPLACE (City or town, State or foreign country) Virginia
PARENTS
NAME OF FATHER O H Neal
BIRTHPLACE OF FATHER (City or town, State or foreign country) Smith Co Va
MAIDEN NAME OF MOTHER Callie Burns
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

(Duration) yrs. 1 mos. 7 ds.
Contributory Weak heart.
(Duration) yrs. mos. ds.
(Signed) R T Gibbs M. D.
3-19-12 (Address) Mexico Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. J. Gant
(ADDRESS) Thompson 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

Filed Mar 19 1912 N J Gant
REGISTRAR

PLACE OF BURIAL OR REMOVAL Thompson Mo. DATE OF BURIAL 3/19, 1912
UNDERTAKER H J Gant ADDRESS Thompson 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.

RECORD WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAI

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