

MARGIN RESERVED FOR BINDING

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

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.

PLACE OF DEATH County <u>Lawrence</u>		MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH	
Township <u>Buck Prairie</u>	Registration District No. <u>4 GP</u>	File No. <u>9924</u>	
Village _____	Primary Registration District No. <u>5629</u>	Registered No. <u>52</u>	
City _____ (NO. _____)	St. _____	Ward _____	[If death occurred in a hospital or institution, give its NAME instead of street and number]
FULL NAME <u>Erett Almore Sullivan</u>			

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>single</u> (Write the word)	DATE OF DEATH <u>February 25</u> , 191 <u>2</u> (Month) (Day) (Year)
DATE OF BIRTH <u>May 13</u> , 191 <u>0</u> (Month) (Day) (Year)		I HEREBY CERTIFY, that I attended deceased from <u>Feb 1</u> , 191 <u>2</u> , to <u>Feb 25</u> , 191 <u>2</u> , that I last saw him alive on <u>Feb. 24</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>6:30</u> a.m. The CAUSE OF DEATH* was as follows: <u>Meningitis</u> <u>79A</u>	
AGE <u>1</u> yrs., <u>9</u> mos., <u>13</u> ds.	IF FEWER than 1 day, ____ hrs. or ____ min.?	(Duration) ____ yrs. ____ mos. <u>21</u> ds.	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		Contributory _____ (SECONDARY) _____ (Signed) <u>Jesse P Baird</u> M. D. <u>Feb 26</u> , 191 <u>2</u> (Address) <u>Marionville, Mo.</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Carterville Mo.</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS	NAME OF FATHER <u>Hyacin Alongo Sullivan</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Lawrence Co. Mo.</u>	Where was disease contracted if not at place of death? Former or usual residence _____	
	MAIDEN NAME OF MOTHER <u>Lola Kingery</u>	PLACE OF BURIAL OR REMOVAL <u>Union</u> DATE OF BURIAL <u>Feb 26</u> , 191 <u>2</u>	
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Lawrence Co. Mo.</u>	UNDER TAKER <u>A. J. Fite</u> ADDRESS <u>Marionville</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. P. Baird</u> (ADDRESS) <u>Marionville</u>			
Filed <u>Mar. 1</u> , 191 <u>2</u> , <u>J. P. Andrews</u> REGISTRAR			

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.)



PLACE OF DEATH

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

County Lawrence
Township Buck Prairie
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 468 File No. 9924
Primary Registration District No. 5629 Registered No. 52

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

FULL NAME Erett Velmore Sullivan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Feb 25, 1912
(Month) (Day) (Year)

DATE OF BIRTH May 13, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 24, 1912, to Feb. 25, 1912, that I last saw him alive on Feb 24, 1912.

AGE 1 yrs. 9 mos. 13 ds. If LESS than 1 day, ___ hrs. or ___ min.

and that death occurred, on the date stated above, at 6:30 a.m.

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

The CAUSE OF DEATH* was as follows:
Meningitis

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

(Duration) x yrs. x mos. 21 ds.

PARENTS NAME OF FATHER Nezakia Kingery Sullivan
BIRTHPLACE OF FATHER (City or town, State or foreign country) Lawrence Co. Mo.
MAIDEN NAME OF MOTHER Solo Kingery
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lawrence Co. Mo.

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

(Signed) J P Baird M. D.
Marionville Mo
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.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J.C. Baird
(ADDRESS) Marionville

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 1, 1912 J P Anderson REGISTRAR

PLACE OF BURIAL OR REMOVAL Aurora DATE OF BURIAL Feb. 26, 1912
UNDERTAKER P. H. Fite ADDRESS Marionville

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DUPLICATE

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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.)