

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.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

PLACE OF DEATH
 County Lawrence
 Township Turnback Registration District No. 476 File No. 9949
 or
 Village _____ Primary Registration District No. 5-640 Registered No. 9
 or
 City _____ (NO. _____ St.: _____ Ward _____)

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

FULL NAME Elin Philfield Gray

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED <u>Married</u> (Write the word)
DATE OF BIRTH <u>Feb 14</u> , 19 <u>12</u> (Month) (Day) (Year)		
AGE <u>64</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) <u>1-002</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Tenn. Miss.</u>		
PARENTS	NAME OF FATHER <u>Daniel M. Gray</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ala.</u>	
	MAIDEN NAME OF MOTHER <u>Susan Bimmon</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Tenn.</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 17, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 20, 1912, to Mar 17, 1912, that I last saw him alive on Mar 16, 1912, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:
gangrenous inflammation of both Parotid glands.
127 B
98 B (Duration) ____ yrs. ____ mos. 25 ds.
115 B
 Contributory (SECONDARY) Chronic disease of gall bladder and ducts.
 (Duration) 5 yrs. ____ mos. ____ ds.
 (Signed) J. P. Andrews M. D.
Mar 17, 1912 (Address) Marionville

*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) Walter Huffman
 (ADDRESS) Stretton Mo
 Filed March 2, 1912 W. Holmes
 REGISTRAR

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 <u>W. Olive</u>	DATE OF BURIAL <u>March 18, 1912</u>
UNDERTAKER <u>J. M. White</u>	ADDRESS <u>Marionville Mo</u>

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

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____
Township _____
or
Village _____
or
City _____

Registration District No. _____

Primary Registration District No. _____

City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day _____ hrs. or _____ min.?
OCCUPATION	(a) Trade, profession, or particular kind of work _____	
	(b) General nature of industry, business, or establishment in which employed (or employer) _____	
BIRTHPLACE	(City or town, State or foreign country) _____	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

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

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

_____ 191____ (Address) _____ M. D.

*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 _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

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) _____

(ADDRESS) _____

Filed _____, 191____ REGISTRAR _____

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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH
County Lawrence
Township Turnback
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 476 File No. _____
Primary Registration District No. 5640 Registered No. 9

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

FULL NAME Elin Whilfield Gray

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH Mar 17, 1912
(Month) (Day) (Year)

DATE OF BIRTH Feb 14, 1848
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 20, 1912, to Mar 17, 1912, that I last saw him alive on Mar 16, 1912, and that death occurred, on the date stated above, at 8 P. m.

AGE 64 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. or min.

The CAUSE OF DEATH* was as follows:

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

stenosis of Biliary ducts with intense pancreatitis about
(Duration) _____ yrs. _____ mos. 10 ds.

BIRTHPLACE (City or town, State or foreign country) Mass

Contributory Secondary idiopathic (Secondary) Parasites (Duration) about mos. 17 ds. (Signed) J. P. Andrews M. D.

NAME OF FATHER David M Gray

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

MAIDEN NAME OF MOTHER Lucy Simmons

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

May 15, 1912 (Address) Marionville
*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) Mrs Leup Huffman

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 _____

(ADDRESS) Stockton Mo.

PLACE OF BURIAL OR REMOVAL mt Oliv DATE OF BURIAL Mar 18, 1912

Filed June 1, 1912 J. P. Andrews REGISTRAR

UNDERTAKER J. M. White ADDRESS Marionville

RECORD B WITH PLAINLY, WITH UNADING IN THIS IS A PERMANENT RECORD

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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) *Colton 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*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, 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.)

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