

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 Pike

Township _____

or

Village _____

or

City Clarksville (NO. _____) (ST. _____) (WARD _____)MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHRegistration District No. 685File No. 3 10507Primary Registration District No. 4409Registered No. 13FULL NAME Frederick Newton Kinsey

[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 single
(Write the word)DATE OF BIRTH Sept 16, 1911
(Month) (Day) (Year)AGE 5 yrs. 4 mos. 25 ds. If LESS than 1 day, _____ hrs. or _____ min.?OCCUPATION
(a) Trade, profession, or particular kind of work Police
(b) General nature of industry, business, or establishment in which employed (or employer) 11.0BIRTHPLACE
(City or town, State or foreign country) MissouriNAME OF FATHER Sam KinseyBIRTHPLACE OF FATHER
(City or town, State or foreign country) Ill.MAIDEN NAME OF MOTHER Myrtle KintonBIRTHPLACE OF MOTHER
(City or town, State or foreign country) Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Kinsey(ADDRESS) ClarksvilleFiled Feb 11, 1912 J. J. Broadway

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 11, 1912
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from Feb 9th, 1912, to March 10, 1912, that I last saw him alive on March 10, 1912, and that death occurred, on the date stated above, at 10 A. m. The CAUSE OF DEATH* was as follows:Congestion of Brain
87 A. V. St.
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(SECONDARY) _____
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) John W. Beuttell M. D.
3/11, 1912 (Address) Clarksville

*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 Clarksville DATE OF BURIAL 3/12, 1912UNDERTAKER W. J. Anderson ADDRESS Clarksville

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

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 Pike

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

Township _____

Registration District No. 685

File No. _____

Village _____

Primary Registration District No. 4409

Registered No. 13

City Clarksville (NO. _____)

St. _____ Ward _____

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

FULL NAME Theird Newton Kirkey

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S

DATE OF BIRTH Spt 16, 1911
(Month) (Day) (Year)

AGE yrs. 5 mos. 25 ds. IF LESS than 1 day, hrs. or min.

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

BIRTHPLACE (City or town, State or foreign country)

PARENTS
NAME OF FATHER Sam Kirkey
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill
MAIDEN NAME OF MOTHER Maggie Keiton
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Kirkey
(ADDRESS) Clarksville

Filed May 27, 1912 W. H. Broadway REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 11, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 9, 1912, to Mar 10, 1912, that I last saw him alive on Mar 10, 1912, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:
Congestion of Brain as the result of Congestive Chill
(Duration) yrs. 1 mos. 10 ds.

Contributory (SECONDARY) _____
(Duration) yrs. _____ mos. _____ ds.
(Signed) John Bartlett M. D.
3/11, 1912 (Address) Clarksville

*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 Clarksville DATE OF BURIAL 3/12, 1912
UNDERTAKER McDuncan ADDRESS Clarksville

Revised United States Standard Certificate of Death

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

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