

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

PLACE OF DEATH

County Marion

Township Smith

Village _____

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

Registration District No. 130

File No. 7 12745

Primary Registration District No. 6254

Registered No. 7

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

FULL NAME Ray Eclair Addisley

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb 13, 1912
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. 17 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) Near Smith, Mo

NAME OF FATHER William Elmer Addisley

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

MAIDEN NAME OF MOTHER Mrs. Susan Adkins

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jasper, Mo close to Carthage

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Elmer Addisley

(ADDRESS) Smith, Mo

Filed Apr 11, 1912 of H. Loggess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 1, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1st, 1912, to Feb 1st, 1912, that I last saw him alive on Feb 1st, 1912

and that death occurred, on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:
Mal. Nutrition
Marasmus
158

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

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

(Signed) Henry E. Tatham M. D. Feb 1st, 1912 (Address) Brunswick, 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 Smith-Cemetery DATE OF BURIAL Feb 2, 1912

UNDERTAKER McLellan Bros ADDRESS Smith Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County _____

Township _____

or Village _____

or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

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

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____ COLOR OR RACE _____ SINGLE OR MARRIED 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 business, or establishment in which employed (or employer) _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

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

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

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191_____, to _____, 191_____,

(Month) _____ (Day) _____ (Year) _____

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 _____ in _____

The CAUSE OF DEATH* was as follows:

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

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

_____, 191_____ (Address) _____

* State the Disease Causing Death, or, in deaths from Violent Causes, state Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

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 _____

PLACE OF DEATH

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

County Carroll
Township Smith
or
Village
or
City

Registration District No. 136
Primary Registration District No. 6254

File No. 12745
Registered No. 7

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

FULL NAME Ray Elmer Budsley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED single
(If write the word)

DATE OF DEATH March 1, 1912
(Month) (Day) (Year)

DATE OF BIRTH Feb 13, 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 1, 1912 to March 1, 1912, that I last saw him alive on March 1, 1912.

AGE 17 yrs. 17 mos. 17 ds. IF LESS than 1 day, hrs. or min.

that death occurred, on the date stated above, at 11:50 a.m.

OCCUPATION (a) Trade, profession, or particular kind of work at home
(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) near Dewart Mo.

(Duration) yrs. mos. ds.

NAME OF FATHER William Elmer Budsley

Contributory (SECONDARY) Gastrointestinal Disturb

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

(Duration) yrs. mos. ds.

MAIDEN NAME OF MOTHER Margaret Susan Budsley

(Signed) Henry B. Gathman M. D.
March 1, 1912 (Address) Brunswick Mo.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Jasper Co. Mo. near Carthage

*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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(Informant) William Elmer Budsley
(ADDRESS) Dewart Mo.

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 March 1, 1912
J. P. Boyan REGISTRAR

PLACE OF BURIAL OR REMOVAL Dewart Cemetery DATE OF BURIAL March 2, 1912

UNDERTAKER McCluskey Bros ADDRESS Dewart Mo.

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, 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 septicæmia," "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.)