

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 Lumbalk
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

Registration District No. 476 File No. 14086
Primary Registration District No. 3640 Registered No. 13

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

FULL NAME Robert Carroll McLeullah

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH March 8th, 1912
(Month) (Day) (Year)

AGE _____ If LESS than 1 day, _____ hrs. or _____ min.?
yrs. one mos. 3 ds.

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) — 0

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

PARENTS
NAME OF FATHER Robert McLeullah
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
MAIDEN NAME OF MOTHER Lora Burk
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert McLeullah
(ADDRESS) Marionville

Filed April 12, 1912 B. G. Halverson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from Mar 8, 1912, to April 11, 1912, that I last saw him alive on Mar 15, 1912, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:
Malnutrition

159
158/51
(Duration) yrs. 1 mos. 3 ds.

Contributory (SECONDARY) _____ (Duration) yrs. mos. ds.
(Signed) M. M. Heulmes M. D.
April 11, 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.

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 W. O. Over DATE OF BURIAL 4/12/12 1912
UNDERTAKER W. O. Over ADDRESS Marionville

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 _____

Township _____ File No. _____

or Village _____ Registered No. _____

or 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 _____

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. _____

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)

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)

DATE OF DEATH _____ (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 _____ m.

The CAUSE OF DEATH* was as follows:

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

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

(Signed) _____ (Address) _____ M. D.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

CONTRIBUTORY

(SECONDARY) _____

(Signed) _____ (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 _____

PARENTS

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 191____

UNDERTAKER _____

ADDRESS _____

REGISTRAR _____

Filed _____, 191____

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 Jurubach
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 476 File No. _____
Primary Registration District No. 5640 Registered No. 13

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

FULL NAME Robert Carroll Mc Bullah

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>m</u>	COLOR OR RACE <u>w</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>S.</u>
DATE OF BIRTH <u>Mar 8</u> , 19 <u>12</u> (Month) (Day) (Year)		
AGE _____ yrs. <u>1</u> mos. <u>3</u> ds.		If LESS than 1 day, _____ hrs or _____ min
OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Mo.</u>		
PARENTS	NAME OF FATHER <u>Robert Mc Bullah</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo.</u>	
	MAIDEN NAME OF MOTHER <u>Clara Burk.</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Mo.</u>	

MEDICAL CERTIFICATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased from _____, 1912, to Apr 11, 1912, that I last saw him alive on Mar 15, 1912, and that death occurred, on the date stated above, at 119 m.

The CAUSE OF DEATH* was as follows:
malnutrition caused by premature birth being only 7 months gestation
(Duration) _____ yrs. 1 mos. 3 ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. M. Halverson M. D.
June 15, 1912 (Address) Marionville 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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Mc Bullah
(ADDRESS) Marionville Mo.

PLACE OF BURIAL OR REMOVAL <u>Mt Olive</u>	DATE OF BURIAL <u>Apr 2</u> , 19 <u>12</u>
UNDERTAKER <u>H. N. Fite</u>	ADDRESS <u>Marionville Mo.</u>

Filed Mar 15, 1912, by P. A. Halverson
REGISTRAR

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.

SUPPLEMENTARY

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 use..... (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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